Physici	an	Decedent's Name (First, Middle, L			2. Date of Death Month	No.2005 21 0
/Medi		Rosann	M. Marx		July	$02^{9} \cdot 200^{9} \cdot 30 A^{-1}$
Examir	ner	4a. Facility Name (If not institution, g.		4b. City, Town, or Location of Death		4c. County of Death
·	d	1302 Haubert St	Sex 7. Age (In yrs. last birth)	Baltimore day) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	N/A
Funeral Director		5. Social Security Number 219–62–4280 Usual Residence of Decedent	Sex 1 M 2 M F 7. Age (In yrs. last birthe	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 09/21/195	9. Birthplace (State or Foreign Country) MD
e Maryland 3a-f show diffied at	ctor	10a. State MD 10b. County	N/A	Baltimore	e City	10d. Inside City Limi 1 X Yes 2 ☐ N
th with the 23a or 21	al Dire	1302 Haubert St	treet	10f. Zip Code 21236	_	Citizen of What Country? USA
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Modical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
within 72 ho ene. then "natur he Madical	Completed	15. Decedent's (Specify only highest g	rade completed) ((Decedeni's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	king 16t	o. Kind of Business/Industry
filed will Hygien other th	Con	12	2	Nurse		Helath Care
uld be fill Mental Hy irked oth	To Be	17. Falher's Name (First, Middle, Las Carroll L.			ne (First, Middle, Mai othy Piers	
nd 2 should be tith and Mental 27 is marked r traumatic ev	ľ	19a. Informant's Name/Relationship Sara Katherine M	(Type, Print) 19b. Marx /Daughter 130	Mailing Address (Street and Number or Run D1 St. Paul Street,	ral Route Number, Ci Baltimore	ity or Town, State, Zip Code) MD 21202
ages 1 ar ant of Hea nt: If Item y or othe		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Spec	Removal from State Bavvier	Disposition (Name of crematory or other place) W Crematory July (altimore Maryland
permit. Pages Department of the Important: If Ite ony Injury or ot once.		21. Signatur a or r sueral Service Lic		Property Name and Address of Facility Charles L. Steve 1501 East Fort A	ens Fune <u>r</u> a	l Home, Inc. ltimore MD 21230
Physician / Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Narcotic intoxica Due to (or as a consequence of b Due to (or as a consequence of c Due to (or as a consequence of):		
ysicier e buri	cal	resulting in death) Last	d): 		
death certifica e attending ph id for use as th	nysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1 Yes 2 No	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
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10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10g		1 - State Ragistrar	C	partment of Health and I ertificate of Death	Reg. I	0.0	<u> </u>
Scotal South Number Company Com	/Medical	George 4a. Facility Name (If not institution, given	Manigo, Jr	4b. City, Town, or Location of Death	July 1	9 2005 4c. County of Death	31.45A
Section Sect		5. Social Security Number 6. S 216–50–4367	Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.		9. Birthpi	
Elementary/Secondary (0-12) College (1-4or 5s) Laborer Landscaper	sa-f show lifted at	10a. State 10b. County				11	0d. Inside City Lin
Elementary/Secondary (0-12) College (1-4or 5s) Laborer Landscaper	23a or 2 uxt be ni rai Dire		reet Apt. 10D		10g. i		try?
Elementary/Secondary (0-12) College (1-4or 5s) Laborer Landscaper	Examiner m	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		pecify Yes or No- o Rican, etc.)	Black, White, e	etc.
The page of the pa	than than months	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) (G College (1-4or 5+)	ve kind of work done during most of wor DO NOT use retired)	king		lustry
Debbie Manigo Wife 401 E. 25th Street Act. 10D, Baltimore, Md. 21 20a. Method of Disposition 15 Gentle (Speech) 20b Piace of Disposition (Name of Secretary Centrality of Address of Facility Centrality Ce	od oth	17. Father's Name (First, Middle, Las.) George	Manigo, Sr.	18. Mother's Nam	ne (First, Middle, Maid an S	en Sumame) ummerville	
Due to (or as a consequence of): Sequentially list conditions, and the same of conditions are sufficiently of the first and s	int: if	1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from State Mt. Z	iposition (Name of remaiory or other place) ion Cem. 7–25 22. Name and Address of Facility	Date 20c. -05 La Baltim	nsdowne, More, Md.	wn, State 1d. 21202
Sequentially list conditions: Sequentially list conditions	nysician /Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition	an Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,		Interval Between
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The property of the property o	be o	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.			
1 yes 2 No 1 Minatient 2 ER/Outpatient 3 DOA 2 Nursing Home 5 Residence 6 Other (Specify)	page 2				autopsy performed	prior to con death?	npletion of cause
3 Suicide 4 Homicide 4 Homicide 3 Suicide 4 Homicide 4 Homi	S 6 5	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur	ient 3 DOA Other: 4 Nursing H	ome 5 Residence)
(Check only one) Check only one) Check only	hours after di meral Directi y filled in by to	4 Homicide determined	building, etc. (Specify) nysician: To the best of my knowledge, de	ath occurred at the time, date and place	City or Town, Sta	ate) (s) and manner as sta	ated.
M 30. Name and address of person who co of ed cause of death (Item 23a) (Type, Print)	within 24 To the Fu completed	one)	and manner stated.	29c. License number	29d. I	Date signed (Month, L	Day, Year)
The same and address of person time of the same of death (notification 200) (1908, FIRE)	1	→ Ammisle	USW mp	AT243894	6 Ju	oly 19,20	005

			Please			. Ensure All Copies	•	
			1 For State	State of Maryland	Certificate of	Health and Mental Hy	A A A	21 000
		-	Registrar 1. Decedent's Name (First, Middle, Las	:(1)	Certificate of	2. Date of De	Rag. No. U U 5	2 Time of Dooth
	Physici /Medic		JAYla	mcce	ottry	July	20 2005	3. Time of Death 10. 28 M
	Examir	er	4a. Facility Name (If not institution, give	HOPKINS Hos	. 44 11	Timore CITY	4c. County of Death	h
Т	Funeral		5. Social Security Number 6. Sec	ex 7. Age (In yrs. la	st birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of Bi	rth 9. Birti	hplace (State or Foreign
	Director		220-63-8183 Usual Residence of Decedent	3	Yrs.	07/01/	1	yland
	arylan show	<u></u>	10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	recto	Maryland Howard	i Co	lumbia		10g. Citizen of What Co	
	h with	Ole	5432 Ring Dove La	an e	21044		U.S.A.	and,
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Hispanic Origin? (Specify Yes or No pan, Mexican, Puerto Rican, etc.)	o- 14. Race - Ame	
21215-0036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Exatrana must be incitified at page.	by Funeral Director	1 ☐Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2½ No			e, etc. 1ack
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. Kind of Business/	Industry
121	within ene. than the Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	·d)	N 7	
d 2	illed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		None	18. Mother's Name (First, Middle	None e, Maiden Sumame)	
Maryland	Aenta Aenta rked tic ev	ToB	Allen McCottry			Sherrie Solomon		
lary	and N Is ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Street	t and Number or Rural Route Numb	oer, City or Town, State, 2	Zip Code)
≥,	and and m 27			other	5432 Ring Dove	e Lane, Columbia	. Maryland	
Baltimore,	ges 1 t of H If itel or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crematory or other pla	107/26/2005	20c. Location - City or	
Ħ.	t. Pa rtmen rtant: njury		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen 	Kin	g Memorial Pk	1	Baltimore,	
Ba	Dep Impo any i		21. Signature of Funeral Service Licen	500		ess of FacilityThe Derric Higts. Ave., Balt		
	* 1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death.				Approximate
	Physician		Immediate Cause (Final	one cause on each line. Re				Interval Between
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseque		wre		2-months
3	Examiner		Sequentially list conditions.	b. Anoxic	Brain Li	Tury		4-months
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):			
I	xecut and	хап	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):			
760,	ate be executed nysician and he burial-transit	calE	l	d				
89	tificating phy as the			u				
Box	th cer lendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal c		ev.	23d. Date of deli	
.O. E	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown		,	Month	Day Year
9	that the ded by detact		Laz II. Other significant conditions of	ontributing to death but not resul	ting in the underlying cause gr	ven in Part I. 23e. Did	tobacco use contribute to	⊌the cause of death?
Records,	quires an sign uld be	ed by	Mental Ketardo	tion and (erebral pale	10	Yes 2 ANO 3 Pro	obably 4 Unknown
900	aw requir as been si 2 should	Completed	Hydrocephalus	with Ventic	cular Deriton	eal Shunt 24a. Was	an 24b. Were au	topsy findings available
R	ysician: The lavis certificate has director, page 2	Com	Swallowing	LICEUM +ina	G-Time dos	auto	ormed? death?	completion of cause of 2 ☐ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to solid I examiner?	14314.	or two siet	26. Place of Death (Check only		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ 10	The state of the s	TVO UPATION 3 DOX	her: 4 Nursing Home 5 Res		cify)
on c	fter The	lon:	27. Manner Death 1 Latural 5 ☐ Pending	(Month, Day Year)	28b. Time of 28c. Injury Wo	ork?	how injury occurred	
Division	Attending redeath. sector: After by the funer	licat	2 Accident investigation 3 Suicide 6 Could not be		me, farm, street, factory, office	Yes 2 No	(Street and Number or Ru	iral Route Number
Ω̈́	al or A s after Il Dire	Certification;	4 Homicide determined	building, etc. (Specify))	City or To	wn, State)	rai riodio railibol,
	lospit t hours unera	cal	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	viedge, death occurred at the ti	ime, date and place, and due to the opinion, death occurred at the time,	cause(s) and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of centier	and manney stated.	29c. Licens			
	7. ½ b 8	7	205. Signature and this of openior	11/19	Dev.	156925	29d. Date signed (Month	i, Day, rear)
	1/1		30. Name and address of person who	completed cause of death (Item	23a) (Type Print) (130 73	1/20/20	703
,			Part 316,60	20 N. Wolfe	Street, Bau	Chimore, MI) à	11287	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar seignatu	ure & Sparke	9		

		•	1 - For State of Maryland		rtment of Hetificate of L			iene 0 0	5 24004
	Physicia	an	Decedent's Name (First, Middle, Last) WALTER A MARTZ				2. Date of Deat Month JULY	th	3. Time of Death 9:45 P M
s.	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		1	4c. County o	f Death
F	uneral		Social Security Number Sex 7. Age (In yrs. la.)	st birthday)	FREDERIC If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	FREDE:	9. Birthplace (State or Foreign
Di	irector		215-36-7380	Yrs.	Months Days	Hours Mill.	Dec 18,	1923	Maryland Maryland
death with the Maryland	show	_	10a. State 10b. County 10c. City,	Town or Loc					10d. Inside City Limits
the M	r 28a-f	Director	10e. Street and Number	.ederi	10f. Zip Code		1	0g. Citizen of Wi	1 ☐ Yes 2 ☑ No
ath with	s 23a o	rai D	6332 Winpenny Drive	. ,		21702			S.A.
UUSO hours after de	Item 27 le marked other then "naturel", or Items 23a or 28a-f show other treumatic event, It e Modical Exeminer must be multified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black	- American Indian, , White, etc. White
13-6	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of wor	rking	16b. Kind of Bus	iness/Industry
A K	er then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ry Farmer			Agricu	lture
and the file	c event	To Be (17. Father's Name (First, Middle, Last) Walter Clayton Martz			18. Mother's Nan Alta	ne <i>(First, Middle, M</i> Irene		amsburg
2 shoul	le marl eumati	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a				-6
1 and Health	tem 27 other tr		Jean Winebrener Martz/Wife 20a. Method of Disposition 20b. Pla	ce of Dispos	sition (Name of				land 21702 Dity or Town, State
altimor	Importent: If Ite any Injury or of once.		1 Buriai 2 □ Cremation 3 □ Hemoval from State 1 □ Donation 5 □ Other (Specify) Mt O	livet	Cemetery	Jul 20			ck, Maryland
permit Depar	any In		21. Signatury of Funeral Service Licensee MO070	22. 6 10	Name and Address Keeney &	Basford	P.A. Fu	neral Ho	ome ryland 21/01
/M	sician edical iminer		23a. Part I. Enter the or ease, or complications that caused the death, shock, or heart (Mure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Do not ente	er the mode of dying	, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
ou, be executed	physician and the burial-transit	1 Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Causa (25.355 or 1 jury that initiated events resulting in death) Last b. Due to (or as a consequence consequence).						
cate	g physic as the b	edical	d						
.O. DOX of	ned by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
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The law requires t	ite has page 2	Completed	Congestive Heart Fa	lure			24a. Was a autops perform 1 Yes 2	ned? pri	ere autopsy findings available for to completion of cause of sath?
ysician: T	s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ E	R/Outpatient	t 3□ DOA Othe	P	th (Check only on		(Specify)
on or ding Phy	After this certifical funeral director, p	Ion: T	1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho		
DIVISION OF VICAL To the Hospitel or Attending Physician: within 24 hours after death.	I Director: od in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		63 2 110	28f. Location (St. City or Town	reet and Number , State)	r or Rural Route Number,
the Hospit in 24 hours	To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know 2 Medicel Exeminer: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my op	inion, death occu	, and due to the ca rred at the time, da	ause(s) and mani ate and place, an	ner as stated. Id due to the cause(s)
- To with	O To coπ	Σ	29b. Signature and title of certifier		29c. License	number	21		(Month, Day, Year)
20) '		30. Name and address of person who completed cause of death (Item :			- 1107		07,11,	20
	` Sta	tė.	31. Date filed (Month, Day, Year) 32. Registrate Signature	olare	Sparle	03, Fu	edenick	MDS	1203
	Registr		JUL 2 2 2005 ▶ Magne	J.	Sporte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Edward Charles Mohr 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Koseda Salvane H More Franklin alt If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Age (In vrs. last birthday) Months XXM 2□ F 90 Director 212-01-9148 28,1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes XXNo Director Maryland Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21221 U.S.A. 6 Capri Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2XNo Yes, Give 1 ☐ Never Married 2 Married ō 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) lal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Sheet Metal Mechanic Aero-Space permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 1s marked othe any injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Mohr Katie Sapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12126 Buttonwood Lane, Baltimore, Maryland 21220 Richard Gale (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory, Ind. July21, 2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of actionski Funeral Home, P.A 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea or condition resuling in death) ADEURYSM. Vascular Disease Prysician /Medical **Examiner** Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical the use as i IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 200 No 1 ☐ Yes To the Hospital or Attending Physiclen: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1/X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i 29a. Certifier 1 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

0

30. Name and address of

31. Date filed (Month, Day, Ye

person who completed cause of death (Item 23a) (Type, Print)
INUT 9000 Frankin Square Drive Baltimore

DO058671

M.D.

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REHABILITATION & EXTENDED N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JUN 26 7. Age (In yrs. last birthday 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Min. 1 X M 2 □ F 86 Director 218-09-1845 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? filed within 72 hours after death with 412 Kings College Drive 21012 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) IXTYes 2 □ No fYes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4X Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Recorder Steel rmit. Pages 1 and 2 should be filed w spartment of Health and Mental Hygien portant: If item 27 is marked other tily injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miller Grant Emma Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Miller - son 412 Kings College Drive, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State permit. Page. Department o important: If I 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 7/22/2005 Beltsville, MD 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, 8/17 Green Pastures Drive, 21. Signature of Funeral Syrvice Licenses anyi M00986 Towson, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (unas a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Yes 2 □No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♥ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificete has page 2 2□ No 2**X** No 1 TYes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 28b. Time of 1 Natural 2 Accident 5 Pending death. investigation 1 TYes 2 🗆 No after death Director: filled in by the Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of to the Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

23a) (Type, Print) COLH RAVEN BLVD BALTIMOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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183			1. Decedent's Name (First, Mic	dle, Last)							2	2. Date of De		Year		ime of Death
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	Examir	ier	4a. Facility Name (If not institut			nber)		4b. City,	Town, or	Location of	Death		4c.	County of De	ath	
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	Funeral Director	· [214-17-2874		4 2[X]F	7. Age <i>(In yr</i> s. 30	Yrs.	Months			Min.	Nov 5	ay, Year)		Country)	State or Foreign
7			Usual Residence of Decedent			50			L			, C VOV.	_19/	+	VA	1
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	72 hours after death with the Maryland "naturel", or Itema 23a or 28a-1 show idical Examinatings be notified at	rai Dire	10e. Street and Number 15 Brooks Road	1				10f. Zip 2:	1014					en of What (USA	Country?	
9	after des	Completed by Funeral	11. Marital Status 1 Never Married 2		. Was Dece Armed For 1 Yes If Yes, Giv	2 📉 No		Was Dece f Yes, spe	cify Cubar	n, Mexican, I	n? (Speci Puerto Ri	fy Yes or No can, etc.)		4. Race - An Black, Wh	nite, etc.	
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lan	and and is mu		19a. Informant's Name/Relatio										er, City or	Town, State	Zip Code,	
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Baltimore,	if ita		20a. Method of Disposition 1 ☐ Burial 2 🌠 Crematio	n 3 ∐Rer	noval from 5	State	Place of Dispo	natory`or o	other place		Dai			cation - City o		
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Ba	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service 23a. Part1. Enter the disease,	e Ri	$\sim\sim$	M01443	CA 87	FA, G	Steph reen	ien D. Pastu	Loh res	rmann, Drive,	PA Tow	son, M	D 21	286
8760,	Physician // Medical Examiner supplies and physician and supplies and	al Examiner	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	•	Seizu Due to (d	re disconsector as a consector as a	uence of): uence of):	ompli	cate	d by c	lrown	ning			Interv	ral Between t and Death
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	in 24 ho in 24 ho hs Fund pletely fi	Medical	29a. Certifier 1 Certific (Check only one)	ring Physic al Examine	r: On the ba and mann	best of my kno sis of examina er stated.	owledge, death tion and/or inv	occurred restigation	at the time i, in my op	e, date and inion, death	place, an occurred	d due to the at the time,	cause(s) a date and	and manner a place, and di	as stated. ue to the ca	ause(s)
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			30. Name and address of person		,	of death (Iter	n 23a) (Type,		PENI	N STRE	ΈΤ,	BALTI	ЮRЕ,	MARYL	AND.	21201
	Sta Registr		31. Date filed (Month, Day, Yea			egistrar's Signa	ture /	11)								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:56 PM GARFIELD B. MATEJ, Jr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW BALTIMORE JOHNS HOPKINS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2 □ F Director 193-30-6750 64 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Churchville Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9 Rhineforte Drive or Items 23a 21028 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Garfield Bohumil Matej, Sr. Gizella (unk) Polahar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jean M. Matej / Wife</u> 9 Rhinofort Drive, Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Highview Memorial Grdns 7-25-05 Fallston, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furjeral Service Licensee McConas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVP Pnysician LONG-STANDING disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F ed by the a ☐Yes 2☐No 9 Unknown 9 🗆 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Division of Vital Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗷 No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after fo tine within 24 hours the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-0061115 JULY 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE, BALTIMORE MD 21224 HARDIN PANTLE MD 4940 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#5, perFH, C845, 7/29/05 TT. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 18, 2005 Year **Physician** Dorothy Jean Mack 9:32 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baldwin Harford 3200 Newfane Court 5. Son 13 05 5 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 19, 1942 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 63 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show wat be notified at Baldwin Harford 1 Yes 2 No Director Md. 10f. Zip Code 21013 10e. Street and Number 10g. Citizen of What Country? ō 3200 Newfane Court or Itams 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner? Black, White, etc. itled within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: δ 3 ☐ Widowed 4 ☐ Divorced "naturs!" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. important: If tiem 27 is marked other than "ne any injury or other traumatic average. Elementary/Secondary (0-12) College (1-4or 5+) private office 12 years medical transcription 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Marie Mullen Edward Franklin DeJoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Newfane Court, Baldwin, Md. 21013 Augustine J. Mack/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gdns. 7/22/05 Timonium, Md. * 4 Donation 5 Other (Specify) 21. Signature of Tyneral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. rant. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cell **Physician** Small Lance ZIMonths resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical ast IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? ţō Month Day 4☐Pregnant at time of death 5 Other (specify) detached The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 this certificate 1 Tes 2 XN0 1 ☐ Yes 2 ☐ No. Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. М 2 Accident investigation within 24 hours after deat To the Funeral Diractor: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 6 hilled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of cestifier 29c. License number 29d. Date signed (Month, Day, Year) 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (harles Kobei 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Maryla	•	artment of H <i>rtificate of L</i>			iene ••. •2 0 0 5	24010
			Decedent's Name (First, Middle, Last	t)			2	. Date of Deat		3. Time of Death
	Physicia /Medic		Mary E. Newto	n				July 12		2:29 P M
>	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
		*	Montgomery Ge 5. Social Security Number 6. S		s. last birthday	01ney		. Date of Birth	Montgome	ery rthplace (State or Foreign
	Funeral Director			om 2∑F 7. Age (my)	Yrs.	Months Days	Hours Min.	(Month, Day) July 5,	Year) C	ountry) ew York
	D.		Usual Residence of Decedent							10d. Inside City Limits
	anylan ahow	7	10a. State 10b. County		City, Town or L					1 ☐ Yes 2 ☑ No
	be Mi	Director	MD Montgom 10e. Street and Number	ery Si	llver S	oring 10f. Zip Code			Og. Citizen of What C	Country?
	with 1			Nov14 Divid			0906		USA	,
	death ms 23	Funeral	3559 S. Leisure	12. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Speci In, Mexican, Puerto Ri	ify Yes or No-	14. Race - Arr Black, Wh	
39	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene item 27 is marked other than "natural", or items 23e or 28e-f ahow other traumatic event, the Medical Evantariant the ricilihad at	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:	ican, etc.)	Specify	hite
aryland 21215-003	72 hou	Completed	15. Decedent's Ed	lucation de completed)	(Give	edent's Usual Occupa	during most of working	unk	16b. Kind of Busines	s/Industry
2	filled within 72 h Hygiene. other than "natient, the Medica	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		E-modes C	
2	Hygier Hygier Ther ti nt, th		12 17. Father's Name (First, Middle, Last)	4			18. Mother's Name (Foreign So Maiden Sumame)	ervices
and	d be f	To Be	William Lowrie Ne				Helen Una	McGinr	nes	
37	2 should be f and Mental I is marked of aumatic eve	-	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street a	and Number or Rural			Zip Code)
≥	1 and 2 Health a tem 27 is		Ann White/sister		unk		- 60			
Baltimore,	Page ent c nt: If ry or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 ☑ Donation 5 □ Other (Specif	Hemoval from State	p. Place of Disp cemetery, cre	osition (Name of ematory or other plac	Da	te	20c. Location - City of	or Town, State
Balti	permit. I Departm Importa any inju		21. Signature of Fun LService Licer	Wad Directo		2. Name and Addres tate Anato altimore,	ss of Facility omy Board MD 21201	655 W.	Baltimore	Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de				respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Rustue	ed	Aorti	c Anei	IRYSI	4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):				,	
		e	Sequentially list conditions. if any, leading to immediate	b. Due to (or as a cons	equence of).					
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	0						
oʻ	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be hysici the bu	dical		d						
Θ			IF FEMALE:	23c. If yes, outcome of pre-	gnancy	10000			23d. Date of d	alivan
Box	death certific e attending p ed for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		Month Month	Day Year
o.	0 0 0	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
s, P	uires that signed b	by Pi	Part II. Other significant conditions		resulting in the	underlying cause giv	ren in Part I.	23e. Did to		to the cause of death?
rds	w require been sig should b	edk	Hypartensi	oN				1 🗆 Y	'es 2□No 3□	Probably 4 Unknown
Record	The law requires that the ate has been signed by the page 2 should be detache	Completed	, ' '					24a. Was autop	sy prior t	autopsy findings available completion of cause of
	The law cate has page 2 :	Con						1 Tes	med? death	es 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	iding Physician: th. After this certifica	10	1 Yes 2 No	28a. Date of Injury	28b. Time	ent 3 DOA	4 Nursing Hom		lence 6 Other (S _i low injury occurred	pecity)
ion	Attsnding or death. actor: After by the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		rk? Yes 2. □No			
Division	Attsndi er death. actor: A by the fu	Certification:	3 Suicide 6 Could not be determined			street, factory, office	2.	8f. Location (S City or Tox	Street and Number or m, State)	Rural Route Number,
	ital or rs afte al Dira	Cert		20101197			<u> </u>			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical Eva	nysician: To the best of my miner: On the basis of exam and manner stated.	ination and/or	investigation in my c	printon death occurre	d at the time.	date and place, and d	ue to the cause(s)
	To t withi To ti	Σ	29b. Signature and title of certifier	, , ,,		29c. Licens	se number	,	29d. Date signed (Mo	inth, Day, Year)
			anthony of le	ale Hel	40	Do	x7176)	very 1d,	1000
			30. Name and address of person who	completed cause of death (item 23a) (Type 21/1/	e, Print)	and G	breat	Olaras	10852 / Manclan. 1
	St	ate	ARTHUR F Was 31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	viardi	wedow S	VII V	U WEY	1414
	Regist		JUL 2 2 2005	and manner stated. completed cause of death (description of the state of the sta	Acan	U				
_				A	-					

Division of Vital Redords, P.O. Box 68760

certificate this After after death. Hospital

within 24 hours a To the Funeral I

7 State Registrar

70

Medical

27. Manner of Death

1 Watural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



28a. Date of Injury (Month, Day Year)

29c. License number

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

D000 4814

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 9/2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1629 Columbia Rd, NW., Suite 334 Washington, De 20009 DeVAughn Belton, mis.

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 2 2005

5 Pending investigation

6 Could not be

determined

32. Registrar's Signature

7/19/05 # 0220 AM Baltimore. Maryland 21215-0036 expired DIANA ORR CKPINEL

		Please T	ype or Print in Black			-		_	
		1 - For Stete Registrar	State of Maryland / De	epartment of r C <i>ertificate of</i>		_	giene Reg. No		21012
Ohuniai		Decedent's Name (First, Middle, Last)	\wedge			2. Date of De		- 000	3. Time of Death
Physici /Medic		Diana H	. ORR.			July	19	2005	2:20A.M
Examin	er	4a. Facility Name (If not institution, give s	100		or Location of Death		40.	County of Death	
Funeral		5. Social Security Number 6. Sex		day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	SACTI M g. Bint	nplace (State or Foreign untry)
Director		0010000	M 201 60 Y	rs. Months Days	Hours Min.	(Month, Da	15	(1).	Virginia
laryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
hours after death with the Maryland hours after death with the Maryland turel; or Items 23a or 28e-f show	ctor	MD BALTI	more T	BALTIMO	RE				1 ☐ Yes 2 🕅 No
with th	Funeral Director	10e. Street and Number	101	10f. Zip Code	221		10g. Cit	izen of What Cou	untry?
eath v	eral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	dOG Hispanic Origin? (Sc	ecify Yes or N	o-	14. Race · Amer	ican Indian.
after d or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 W No If Yes, Give	If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.
hours urai',	d by	3 Widowed 4 Divorced	Year or Dates:		Specify:			Specify: Blo	ack
2 2	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of work	ing	16b. K	ind of Business/I	ndustry
filed within 72 Hygiene. Wher then "nater," I.N. Me. Jic.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	captionic	5+		Ti	+le Co	mpany
be file tal Hy d oth svent	Be	17. Father's Name (First, Middle, Last)		ı	18. Mother's Nam	e (First, Middle	, Maiden	Sumame)	1.
nd 2 should be filed within and 2 should be filed within and Mental Hygiene. 27 le marked other then fraumr traumatic svent, ILM Me.	2	19a, Informant's Name/Relationship (Ty	one Print) 19b	Mailing Address (Street	and Number or But	e FOO	ner City o	or Town State Z	in Code)
and 2 s and 2 s eelth ar m 27 ie	-	Robert C. Ori	95	03Hallh	urst Ro	1. BAL	Tin	20RF 1	1021234
of He		20a. Method of Disposition 1 Burial 2 Cremation 3 R	comotoni	Disposition (Name of crematory or other pla	89/6	Date	20c. L	ocation - City or 1	Fown, State
Pages tment of tant: if it		`4 □ Donation 5 □ Other (Specify)	Evansfi	pheralch	1	2-05	FO	rest H	11 MP
permit. Pages 1 and 2 Department of Heelth a Important: if Item 27 ie any injury or other trau		21. Signature of Funeral Service Licente	2011 P.	22. Name and Address	ss of Facility 232				CEMATION CTA
_		23a. Part 1. Enter the disease, or compl	ications hat caused the death. Do no	ot enter the mode of dying	ng, such as cardiac			PACCO	Approximate Interval Between
Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition		Incer					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a sensequence of						7764119
Examine.	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	():					
a executed an and urial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events		•					
e exection and an arrial-tr	_	resulting in death) Last	Due to (or as a consequence of):					
The law requires that the death certificate be site has been signed by the attending physicis page 2 should be detached for use as the bur	Physician/Medical		1						
nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	• -				23d. Date of deli	very
death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Month	Day Year
hat the de de by the detached		9 ☐ Unknown ** Part II. Other significant conditions con		the underlying cause on	ven in Part I	23e. Did	tobacco	use contribute to	the cause of death?
uires that n signed t	d by					,			bably 4 Unknown
aw require s been sl	piete					24a. Was		24b. Were au	topsy findings available
The lav	Completed					auto perf 1 Yes	ormed? 2 No	death?	ompletion of cause of 2 No
Physicien: The ribis certificete	Be	25. Was case referred to medical examiner?	Hospital:	O#	26. Place of Dear				11 3
physical distribution of the control	To To	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injury 28b. Til	me of 28c. Inju	her: 4 Nursing Hory at	ome 5 Res 28d. Describe		6 Other (Spec ry occurred	ity) Hospice
ath. or: Afte	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inj	ury Wo M 1□	rk?]Yes 2□No				
br Atter de lirecte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office		28f. Location City or To	(Street ar wn, State	nd Number or Ru e)	ral Route Number,
spitel ours al		29a. Certifier 1 Certifying Physical	sician: To the best of my knowledge,	death occurred at the ti	me date and place	and due to the	cause/s) and manner as	stated
To the Hospitel or Attending Physicien: within 24 hours after death within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director;	Medical								
To the To the comp	Σ	29b. Signature and title of certifier	Λ 0	29c. Licens	se number		29d. Da	te signed (Month	, Day, Year)
7		1/ Inlam	y fally, mo	1).7	2402		10	719,0	×00.7
10		30. Name and address of person who co	mer: On the basis of examination and and manner stated. July Manner sta	N. Charle	= St. B	alto. V	nd	21204	
Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	Sopole					
Registi	ar	JUL 2 2 2	UUD Blower St.	19					

		For State Registrar	State of Mai	-	Department of I Certificate of			iene 005	24013
Physic /Medi		1. Decedent's Name (First, Middle, L.	MAC	R	Att		2. Date of Death	Day QOU	3. Time of Death
Exami	ner	4a. Facility Name (If not institution gives the second of	5 HOSAY	(In yrs. last bin	Ballings Hoday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	4c. County of Dea	ath rthplace (State or Foreign ountry)
Director		216-30-9723 Usual Residence of Decedent	10 M 2/4 F	70	Yrs.		Jan 6,	1935 Ma	
ryland thow		10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1
he Ma 28e-f s	Director	Md. N/A		Balt	imore		1/1	0g. Citizen of What C	/ •
3s or 3		10e. Street and Number 1003 N. Ella:	mont Stree	2 +	2121	6		USA	ountry:
Ind 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "netural", or Items 23s or 28e-f show event, the Modical Exc. when wast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of I	Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
15-0036	eted	15. Decedent's E (Specify only highest g.	Education rade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of worki	ing i	16b. Kind of Busines:	s/Industry
N pos	Completed by	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Las	College (1-4or 5+ Unknov		Liba	9d)		Libr	ary
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	To Be	Norman A. Ma	·				•		
re, Marylar 1 and 2 should be 1 Health and Menta 11em 27 is marked other traumatic ex	_	19a. Informant's Name/Relationship	(Type, Print)		Mailing Address (Street				
		Stephen Prat 20a. Method of Disposition	t (son)		003 N. El Disposition (Name of y, crematory or other pla			Baltimore	e Md 21216 r Town, State
timo trment o rrant: If njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify) 2	1	y, crematory or other pla Memorial 22. Name and Addro	Park 7/2	5/05	Windsor	Hill, Md.
Bal permi Depa Impo any is		Levis	Gwynn	,	Lewis		Funer	al Home	21215-6393 MD-
Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition	nplications that caused t	he death. Dor	not enter the mode of dyi	ing, such as cardiac o	or respiratory arre	e Barro est,	Approximate Interval Between Onset and Death
/Medical Examiner	er	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a	14 4	gomin	42 14	Noh e	phe_	
58760, ficate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):				
Geath certi	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	sy .		23d. Date of de Month	elivery Day Year
I Records, P.O. The law requires that the ate has been signed by the page 2 should be detached.	ed by Ph	Par II. Other significant conditions	contributing to death but	not resulting in	the underlying cause gr	ven in Part I.			to the cause of death?
DIVISION Of VITAI RECORDS, or Attending Physician: The law requires I after death. Director: After this certificate has been signe in by the funeral director, page 2 should be it.	Complete	Severe ler	· Pheral	\ \Ae	see Ar I	Sease	24a. Was ar autops perform 1 Tyes 2	n 24b. Were a prior to death?	utopsy findings available completion of cause of
Vital F sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	t2 ER/Ou	tpatient 3 DOA	26. Place of Death		e) nce 6 □Other (Sp	agifu)
ion of nding Phys ath. r: After this e funeral di	I	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day		Time of 28c. Injury			w injury occurred	Sury
Division of Vita with the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica compistely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not determine		y - At home, fa (Specify)	rm, street, factory, office		28f. Location <i>(Str</i> City or Town	reet and Number or F , State)	Rural Route Number,
To the Hospitel within 24 hours: To the Funeral completely filled	Medical	(Check only 2 Medical Ext	Physician: To the best of aminer: On the basis of e and manner state	examination an	d/or investigation, in my		ed at the time, da		e to the cause(s)
T viiii		29b. Signature and title of certifier	Dernole	951	NDD	27163	3	57/18/	2005
(5)		30. Name and address of person who	Nolds B	ath (Item 23a)	(Typē, Print)	latopotal	of	Baltin	eve
St Regist	ate trar	31. Date filed (Month, Day, Year) JUL 2 2 2		's Signature	1 11 -				
DHMH 17 Rev 1/3	2001		- Jacobson		upares				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** AM APKG ILL. Ar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BASTIT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min Months Hours 1 M 2 □ F Yrs Director 145-12-169 81 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examiner riust be notified at 1 ☐ Yes 2 No Director HARFOR A PARTENO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 1410 71017 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ 2 Yes 2 No If Yes, Give Year or Dates: W. W. III 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event the stream of the stream 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 € Widowed 4 □ Divorced WHILE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 111012X 12785 73 YUZ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) N.II. Am 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JIBRA 41016 ONB 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 16 1206 1 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Fune of Service Licenses A.R.P.A -Bouce 2150 EVAN FUNG PORTORIVE FOREST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Enysician molion 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listers of injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) Yes the be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 25 No After this certificate has 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 28 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Injury Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03556 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		T = State Registrar				Ce	rtificat	e of L	Death			Reg. Mc	2005	C	24015
Physici			me <i>(First, Middl</i> e, E il een Pr	,							2. Date of E Month July	Death Da	y y 200	'ear 0.5	3. Time of Deat
/Medic Examir				give street and num	ber)				Location of			40	. County of	Death	
Funeral		5. Social Security	Number 6		7. Age (In yrs.	last birthday)	If Under	r 1 Year	SVill If Under	24 Hrs.	8. Date of B	lirth	Balti		CE place (State or Fore ntry)
Director		213-12-8 Usual Residence		1 M XXF	88	Yrs.	Months	Days	Hours	Min.	Sept.	18]	1916		aryland
natural', or iteme 23a or 28a-f show	ō	10a. State	10b. County Balti	imore		y, Town or Le								•	10d. Inside City Lin 1X Yes 2 □
r 28a-	rect	MD 10e. Street and N	1	IMOTE	Ca	COIISVI	10f. Zip	Code				10g. Ci	tizen of Wh	at Cou	ntry?
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Physician /Medical Examiner Funeral Director Physician 4a. Facility Name PININGS 5. Social Security 184–52– Usual Residence	CRYSTA (If not institution, give //A Reg/o/ Number 6. S. 6212 of Decedent 10b. County	E E E E E E E E E E E E E E E E E E E	oer) d/ C		4b. City, Town, or	Location of De	Month July	Day Year 20, 2005	8:00 A M
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10e. Street and N		LSEL		·	10f. Zip Code	sfield		10g. Citizen of What C	ountry?
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11. Marital Status		12. Was Deced	ent Ever in U.S	S. 13. V			(Specify Yes or No- erto Rican, etc.)		
© 2 3 Widowed	rried 2🏹 Married 4 🗌 Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	ŊNo		Yes, specify Cuba ☐ Yes 2 No	n, мөхісап, Ри Specify:	erto Hican, etc.)	Black, Wh	White
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Patrick	A. Potter	(Husbar	(D)		00897 CRIVET 1			ld, Harvla	' '
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A Part II. Other sign	nificant conditions co	ontributing to dea	th but not resul	Iting in the un	derlying cause give	n in Part I.	23e. Did tot	bacco use contribute t	the cause of death?
Cords w require been sig should be							1 □ Y∈	es 2 No 3 P	robably 4 Unknown
Il Records, The law requires t age to sale has been signe page 2 should be Completed by							24a Wasa		utopsy findings available
The table table page							autops perforr	ned? death?	completion of cause of
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	ath 5 ☐ Pending investigation		Injury Day Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ∐ No	28d. Describe ho	ow injury occurred	
Division of a distribution of	6 ☐ Could not be	28e. Place of	Injury - At hor	me, farm, stre	et, factory, office			reet and Number or R	ural Route Number,
Div real or A de la		Building	, etc. (Specify)	,			City or Town	1, 3(4(9)	
Division To the Hospital or Attending within 24 hours after death, within 24 hours after death. To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the fune (Check only one) To the Hospital or Attending within 2 hours after death. Medical Certifier (Check only one) To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death. To the Hospital or Attending within 2 hours after death.	Certifying Phy	ysician: To the b niner: On the bas and manne	is of examination	vledge, death on and/or inv	occurred at the time estigation, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. a to the cause(s)
29b. Signature ar	d title of certifier	-			29c. License			9d. Date signed (Moni	h, Day, Year)
of 1	pm				D5	4807		7-20-	05
() lames	dress of person who d	completed cause	of death (Item)	23a) (Type, F	Print) '57: 50	listur	y mo	21801	
State 31. Date filed (Ma Registrar	onth, Day, Year)	32. Re	ristrar's Signatu	Ure Ur A	nevie		y, mo		

			1 - For State Registrar	State of N	Maryland / Dep Ce			ental Hygie		21.017
ı	Physici /Medi		Decedent's Name (First, Middle Anna Radomski	le, Last)				2. Date of Death Month 07/20/	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution Future Care Ch		or)	4b. City, Town, o	or Location of Death	0.7207	4c. County of Death Anne Ar	h ~
	Funeral Director		5. Social Security Number 215–03–6668 Usual Residence of Decedent	6. Sex 7. / 1 ☐ M 2 ☐ F	Age (In yrs. last birthday 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 07/26/1	9. Birth Co.	nplace (State or Foreign untry) MD
	Maryland -f ahow	tor	10a. State 10b. County	Baltimore	10c. City, Town or L		rbutus			10d. Inside City Limits 1 □ Yes 2 □ No
	th with the 23a or 28a ist be noti	ai Director	10e. Street and Number 1258 Map.	le Avenue		10f. Zip Code		21227	g. Citizen of What Co	untry? Usa
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f ahow other treumetic event, II a Medical Evan it act must be notified at	d by Funerai	11. Marital Status 1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	s? ₫ ¼ o	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
2121	filed within 72 h Hygiene. other then "natu ant, tre Medica	Completed	(Specify only higher Elementary/Secondary (0-12) 12	at's Education st grade completed) College (1-40	(Give	edent's Usual Occup e kind of work done DO NOT use retire Supe:	during most of worki d) T	ing	Spice Co	•
Maryland	should be fill and Mental H. marked oth	To Be	17. Father's Name (First, Middle, Stanislaus Ra					e (First, Middle, Ma ances Str	,	
, Mar	and 2 sho lealth and m 27 Is ma her treums		19a. Informant's Name/Relations Kevin J. Cado				and Number or Rura Avenue, An		City or Town, State, Z.	ip Code)
Baltimore	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition → Burial 2 □ Cremation → 4 □ Donation 5 □ Other (S	Specify)	Holy Ros	osition (Name of ematory or other place sary Ceme	ca)		c. Location - City or 1 Baltimore	
Balt	permit. Departi		21. Signature or Fun, ral Service	Licensee Victo	>	harles L. 1501 E. Fo	Stevens ort Ave.,	Funeral Baltimore	Home, Inc. e MD 21230)
8760,	The law requires that the death certificate be executed The has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a d. Due to (or	ed the death. Do not en line. a consequence of): Lunc a consequence or). LYH is a consequence of):	Lear Lear Cardio	ng, such as cardiac of	or respiratory arrest		Approximate Interval Between Onset and Death YEars Years Years Years
.O. Box 6	at the death certific by the attending prached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy	/		23d. Date of deliv Month	very Day Year
ords, P.	w requires that been signed t should be det		Part II. Other significant condition chronic ren	ons contributing to death	but not resulting in the c	underlying cause giv	ment.	23e. Did tobad	cco use contribute to	the cause of death?
Vital Records,		Completed by	celluli'	S's				24a. Was an autopsy performer	prior to co	oppy findings available ompletion of cause of
of	or Attending Physicien: Thater death. Director: After this certificate in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investit 2 Accident investit 3 Suicide 6 Could	Hospital: 1 Inpai 28a. Date of In (Month, D) gation not be		of 28c. Injur Wor M 1	y at k? Yes 2 □ No	me 5 Residence 28d. Describe how	e 6 □ Other (Speciniqury occurred	
Div	Hospital or Al 24 hours after or Funerel Direct letely filled in by		4 Homicide determ	building, o	etc. (Specify)			City or Town, S	State)	
	To the Hospital or within 24 hours after To the Funerel Director completely filled in b	Medicai	(Check only one) 2 Medical 29b. Signature and title of certifie	and manner s	of examination and/or in	in occurred at the till ovestigation, in my o	pinion, death occurre	ed at the time, date	and place, and due t Date signed (Month,	o the cause(s)
)	A		XIM		97		~ D41	957	7-20	.05
7) -		30 Name and address of person	Elon M	D 860/	Verre	ins His	hwar	Mole	usuille lux
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	de la	()	0	1	21108

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Elizabeth В. Rose July 13 2005 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 916 Lance Ave. Essex Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 25 F 216-30-8248 Director 72 Oct.16,1932 MAryland Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "neturel", or items 23e or 28e-f shot treumetic event. The Medical Evandance must be notified at MD Funeral Director Baltimore 1 ☐ Yes 2 ☐ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 LAnce Ave. 21221 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ş Specify.White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home . Pages 1 and 2 should be filled wi tment of Health and Mental Hygien tent; If item 27 Is marked other th jury or other treumetic event. 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Self Viola Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbur Rose / husband 916 Lance Ave. Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department Importent: If any injury o Oak Lawn Cemetery 7/16/05 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 MACE Ave. Baltimore MD 21221 not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only or e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Vascular Physician pertensus Atherocelerote 5 year /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 212 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30555 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Point Ad, Dull, no 21219 Hlan 7566 ny 32 Begistrare Signature 31. Date filed (Month, Day, Yea State Elegise. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:56 PM **Physician** ROSS 2005 duti /Medical 4b. City, Town, or Location of Death Ball h nune 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Medical Couter Mercy If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2□F 2/3-88-1624 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 ia marked other then "naturel", or itema 23a or 28e-4 show any injury or other traumatic event, I'm Medical Examinat must be notified at Maryland 1 XYes 2 ☐ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shiva Sher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (mother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2005 Metro Cremator 22. Name and Address of Facility
JOSEPH L. RUSS FUR
2222 W. North Ave. 21. Signature of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Euclocardin Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner wchemia burial-transit Myocardi Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes Inpatient 2 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ACTEN DING 056399 dry 19,2005 8 PHYSICIAN

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

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address of coson who completed cause of death (Item 23a) (Type, Print)

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amend item#26, per MD, G845, 7/22/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year ee 06:06p M /Medical 20 2005 4a. Facility Name (If not institution, give street and number) 412 Royalton Rd. 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Cay, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1⊠M 2□F 244-42-8034 Yrs Director North Carolina 08-03-1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at MD Director Montgomery Silver Spring 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 412 Royalton Rd. 20901 USA or Items 23a death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or leaven any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2X No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Specialist 12 Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Graham Royster Carrie Belle Davis ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma E. Royster (wife) 412 Royalton Rd. Silver Spring MD 20901 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Commetery, crematory of other place)
Uniform Services of the 1 Burial 2 Cremation 3 Removal from State * 45 Donation 5 ☐ Other (Specify) Health Services 07/07-2005 Bethesda MD 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licenses Acruse Wood 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) UH to ras a consequence of): /Medical Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760; Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ίο in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown þ ate has been signed page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 YOS 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2K No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Sidence 6 Other (Specify) Hospital: 27 NO Certification; To 1 Tyes 2 Produtpatient 1 🗌 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. sescribe how injury occurred within 24 hours after death. To the Funaral Diractor: After Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) COYOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul_Hammer 4301 Jones Bridge Rd. Bethesda, MD 31. Date filed (Month, Day, Year) State Registrar 2 2 2005

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ORIGINAL

			For State Registrer	e of Maryland		artment of l tificate of			Reg.	2005	24021
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Death Month	200°	3. Time of Death
	/Media		Santina M. Riley								
7	Examir	ier	4a. Facility Name (If not institution, give street at Morningside Assisted			4b. City, Town, Ellico				4c. County of De Howard	ath
			5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthdav)	If Under 1 Year		24 Hrs. 8 I	Date of Birth	9 B	rthplace (State or Foreign
	Funeral Director		215-05-1759 1 M 2	if 88	Yrs.	Months Days	Hours	Min. Al	(Month, Dey, Ye JG 4 191	.6	rthplace (State or Foreign Country) PA
	D		Usual Residence of Decedent								1
	aryiar ehow	_	10a. State 10b. County	1 '	, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Me M	octo	MD Howard	E	LIICOE	t City			10-	Olivier and high and of	
	with the	Funeral Director	10e. Street and Number	NO.		10f. Zip Code 21042			10g.	Citizen of What C USA	ountry?
	eeth met	era	5330 Dorsey Hall Dri	Decedent Ever in U.S	S. 13. V			igin? (Specify	Yes or No-	14. Race - Arr	encen Indian,
10	filer d	듄	1 Never Married 2 Married 1	ed Forces? Yes 21∦∑No		Vas Decedent of i			in, etc.)	Black, Wh	ite, etc.
ဗ္ဗ	ours a	<u>م</u>	3 ☑ Widowed 4 □ Divorced If Ye Yea	s, Give or Dates:	1	☐ Yes 2 🔀 No	Specify:			Specify: W	hite
21215-0036	within 72 hours after deeth with the Maryland she. then "natural", or iteme 23s or 28s-1 ehow ta Madical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple	eted)	(Give	lent's Usual Occu kind of work done	during mos	t of working	16b	Kind of Busines	s/Industry
121	Athin Pen.	臣	Elementary/Secondary (0-12) Colle	oge (1-4or 5+)		OO NOT use retire	ed)			orm ho	
	Hygie Hygie nt, th		17. Father's Name (First, Middle, Last)	<u></u>	Homem	aker	18. Mothe	er's Name (Fil	rst, Middle, Maid	OWN hor	ile
au	d be a	To Be	Samuel Rizzo					vanina	Bonna		
Maryland	shoul nd M mari	1-	19a. Informant's Name/Relationship (Type, Prin)	19b. Mailin	g Address (Street	and Number	er or Rural Ro	oute Number, Cit	y or Town, State,	Zip Code)
	od 2 27 is		Raymond Lee Riley - so	n	6353	Summercr	est D	rive, (Columbia	, MD 2:	1045
ĕ,	of Her		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of natory or other pla	ice)	Date	20c.	Location - City o	r Town, State
Ē	Pege nant ant: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Irom State		Crematoy 1		7/23/20	005 Be	ltsville	e, MD
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth end Mental Hyglene. Importent: if item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event, it a Madical Examinar must be notified at Once.		21. Signature of Funeral Service Licensee	M00986	CA 22	Name and Addr FA, Step 17 Green	hen D Pasti	Lohr	mann, PA	owson, M	21286
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death.	. Do not ente					,	Approximate Interval Between
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1	/Medical		resulting in death)	e to (or as 1 consequ	ence of	10 /1	1 000				
	Examiner	_	Sequentially list conditions, b.	wea	WITH	B (1)	con	S			
	ed sit	lhe	Sequentially list conditions, if any leading to himselfiate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequ	ence orp						
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Records,	hesbe pe2sh	Completed							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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of Vital	Physicien: Th this certificete rei director, pag	Be	25. Was case referred to medical examiner? Hospital:			Ott	200		neck only one)	-	
t o	Phys this rei dir	2	1 Yes 2 10		R/Outpatient 28b. Time of	3 DUA	4 140		5 ☐ Residence Describe how in	6 ☐ Other (Speiury occurred	acify)
on	Attending I r death. ector: After by the funer	후	1 □ Matural 5 □ Pending 2 □ Accident investigation	Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2.∐.l				_
Division	i or Attendil efter death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At hor		et, factory, office		28f. I	Location (Street City or Town, Sta	and Number or F	ural Route Number,
á	s efter s efter of Direct	Certification;	4 Homicide	ouilding, etc." (Specify)					City of Town, Sta	110)	
	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: After th completely filled in by the funerel	Medical	29a. Certifier 1 Cartifying Physician: 1 (Check only one) 1 Medical Examiner: On and								
	To th To th comp	M	29b. Signature and title of certifier			29c. Licens	se number	75/	29d. [Date signed (Mon	th, Day, Year)
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	h		30. Name and address of person who completed	11/11	55/	He H	utilix	ent	PRULL	v Colu	mbia, MO
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	JIP JOSA	K)			//	1	2104
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 115 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 Year **Physician** 2005 2:10 A George Klein Radcliffe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 115 Upper Chesapeake Medical Center Bel Air Harford Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** M2000 5 1**X** M 2□ F Director June 30. 1934 New York 129-26-0767 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or Items 23s or 28s-1 ehow traumatic event, the Medical Exarginal rectivative rotified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with 109 Woodland Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: þ 3√2 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor Communications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Is marked of Harold Francis Radcliffe Lillian Marie Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is eny injury or other trains 109 Woodland Drive, Bel Air, MD 21014 George S. Radcliffe / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7-19-05 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee eny 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ICA Shroke Massine **Physician** /Medical Due to (or as a consequence of): Examiner Metastahic Disease Liver Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): burial-Physiclan/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death NA 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) the MA o 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury Natural 5 Pending NA 1 ☐ Yes 2 ☐ Ño death. investigation N/A NA 2 Accident Diractor; 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital or MA NA within 24 hours a To the Funeral C 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062704 07.17.2005 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Ber MD21014 Medical Kastik

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

22

ORIGINAL

32. Registrar's Signature

		1- For Amend Items 7,8 per SA, C345, 07/29/05dhb Certificate of Death	Mental Hygi	ene	01.000
	-	Negistrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	2003	4 3. Time of Death
Physic		Arthur Booker	Month	Day Year	- 12 P.M.
/Med Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
LXuiii		Arden Courts - Kensington Kensington, Ma		Montg	- 1
Funera		5. Social Security Number 6. Sex 1/2/3 M 2 F 81 7. Age (In yrs. last birthday) 1/2 Months Days Hours Min.	8. Date of Birth (Month, Day	Year) 1/240. Bi	rthplace (State or Foreign ountry)
Directo		Usuel Residence of Decedent	2111	110	w York
yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Mar	ctor	MD Montgomery Kensington			1 A Yes 2 No
5-0036 72 hours after death with the Maryland "netural", or Items 23s or 28s-f show idical Examples for rediffed at	Funeral Director	10e. Street and Number 10f. Zip Code 20904	10	g. Citizen of What C	- 1
deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
0036 hours after ural; or Ite	by Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give			ucasian
15-003 72 hours "netural",		15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Business	s/Industry
Ind 21215-0036 be filed within 72 hours af tal Hygiene. Id other than "naturel", or event, the Medical Exam	Completed	(Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired) 12 (Give kind of work done during most of work life. DO NOT use retired) 12 [College (1-4or 5+)] 12	cher i	Federal G	accernment
	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M		9
	ToB	Charles Rocker Elsie	Neuf		
lary		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	ral Route Number,	City or Town, State,	Zip Code) 20906
and and health m 27		Adele Rocker/spouse 3310 N. Leisure World		Oc. Location - City of	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke injury or other treumatic.		1 Burial 2 Cremation 3 Removal from State 1 Burial 5 Cremation 5 Removal from State	Duits	oc. Eccation - Only of	TOWN, State
Balt permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee Anatomy Board Baltimore, MD 2120	1 655 W. 1	Baltimore	Street
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician	6.3	Immediate Cause (Finel disease or condition a. Hypertunsial Hart	Discus	l	Unset and Dealit
/Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. Due to (or said consequence of): Sequentially list conditions.	11/11/5	6.	
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- (
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
8760, sate be executed thy sician and the burial-transition in the burial-transition.	Exa	resulting in death) Last Due to (or as a consequence of):			
Box 68760, eath certificate be exe attending physician are for use as the burial-i	dicai	d			
	Med	IF FEMALE:		1	
BOX 6 death certific	Physician/Me	23b. Was decedent pregnant in the past 12 months? Description 1		23d. Date of de Month	Day Year
P.O.	iysic	1 Yes 2 No 9 Unknown			
cords, P. w requires that sheen signed by should be deta	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?
v requ	etec		24a. Was an	24b. Were a	utopsy findings available
Re la he la se has ge 2	E C		autopsy perform	prior to death?	completion of cause of
# 0	0	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes 2: th (Check only one		5 2 1110
4 × ×	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residen	ce 6 Other (Spe	ecify)
Division of tor Attending Physatter death. Director: After this in by the funeral di	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No	28d. Describe how	v injury occurred	
VISION Attending r death. ector: After	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or F	Pural Route Number,
Div el or s after od in b	Serti	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)	
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)
- 22 - 0		I thomas V. Mosque Doo473	30	7/18/05	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50. W - EDMONSTON DR. ROCKVILLE.	4D 20	852	
S	ate	31. Date filed (Month, Day, Year) 22. Registrads Signature			
Regis	- 4	JUL 2 2 2005 Beaux S. Species			

			1 - State of Maryland State of Maryland		artment of H			ene 005	5 24	025
п			Decedent's Name (First, Middle, Last)				2. Date of Death)		Time of Death
ı	Physici /Medio		Monah Charge				Month June	Day 1	/ear	200 M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		4c. County of		
			SHADY GROVE ADVENTIST HOSPITAL		Rockv	ille		Monte	gomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			(State or Foreign
	Director		219-35-5578 1 ¹ 3C F 50	Yrs.	July Duy	7100.0	Apr. 14,	1955	Liber	ia
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City	Town or Lo	cation				104 1	anida Circ tilade
	daryl f sho	ō			rsburg					nside City Limits □XYes 2□No
	the 28a-	ect	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh		
	ath with 23a or	Funeral Director	7904 Spiceberry Cicle #G		20877		10	Liberia		
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2⊠ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American In White, etc.	
20	72 ho	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupa	ation		6b. Kind of Busi	ness/Industry	,
2	within one. than 'r	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done of OO NOT use retired))	rking			
	e filed within al Hygiene. I other than ' vent, I'le Me	Completed	4		Counsel	or	u.	WK .	•	
Maryland	be fit ital H od ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, M	aiden Sumame)		
yla	should be nd Menta marked umatic ev	၉	Thomas Sackor			Esther	Sakor			
Nar	2 sh and is m rsum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ıral Route Number,	City or Town, St	ate, Zip Code	3)
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		William Sharpe / Husband		Spiceber	ry Circl		thersbu	-	
Baltimore,	Pages 1 nent of H int: If ite iry or ot		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, cren	sition (Name of natory or other place	· 1	Date 20	0c. Location - Ci		
ţ	t. Pa rtmer rtant rjury		# #		leaven Cer			Silver		g, Md.
Ba	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service License	. 111/	Name and Addres	O.	apitol Mo , NE Was		Inc. 20002	
			23a. Part1. Enter the disease, or or mp ications that caused the death shock, or heart failure. List of ly the cause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,	Appr	roximate val Between
	Physician		Immediate Cause (Final disease or condition	B-	eart (12				et and Death
	/Medical		resulting in death) Due to (or as a consequ	ence of):		ALC.				7.5
	Examiner		Sequentially list conditions, b.							
E	ad sit	lie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):						
	and I-tran	Examiner	Cause (Disease or injury that initiated events c							
68760,	cate be executed physician and the burial-transit	a E	bue to (or as a conseque	511 CO 01).						
387	phys phys the	edlcal	d							
P.O. Box (Attending Physicien: The law requires that the death certifics rideath. r death. ector: After this certificate has been signed by the attending pr by the funeral director, page 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date o Month	,	Year
	that ed by deta	H H	Part II. Other significant conditions contributing to death but not result	ting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribu	ite to the cau	se of death?
Vital Records,	w requires been sign should be	ted by					1 □ Yes	2 X No 3[Probably	4 Unknown
Sec	has by	Completed					24a. Was an autopsy performe	prio	r to completion	ndings available on of cause of
a	ysician: The is certificate hadirector, page		OF Wee case referred to medical				1 ☐ Yes 2		Yes 2	10
Ĭ	sicial	Be c	25. Was case referred to medical examiner? Hospital:		Othe		th Check only one)			
of	Phys r this sral di	7: To	27. Manner of Death 28a. Date of Injury	R/Outpatient 28b. Time of	3☐ DOA 28c. Injury		ome 5 Residence		(Specify)	
Division of	ding f th. : After s funer	ertification;	1 ★Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work	es 2 No	Log. Describe now	injury occurred		
<u> </u> S	deal deal ctor	fica	3 Suicide 6 Could not be	ne, farm, stre		32 23.10	28f. Location (Stree	et and Number o	or Rural Route	a Number
ă	ai or / s after il Dire	Certi	4 Homicide determined building, etc. (Specify)	,,	or, radiory, orno		City or Town,	State)	or ribrar rioble	s Number,
		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	ledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cau- red at the time, date	se(s) and manne and place, and	er as stated. I due to the ca	ause(s)
	withir To th comp	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (A	Month, Day, Y	'ear)
,	1		Parkanner		444	6033-			9 ~	225
2	N		30. Name and address of person who completed cause of death (Item :	23a) (Type, F		60335		une !	, 20	
2			18111 Prince Philip D	ri va	*rint) #327	olne	M.D	20	832	
	Sta	te	31. Date filed (Month, Day, Year) JUL 2 2 2005 31. Registrar's Signature	re don	100 E		/			
	Registra	ar	OUL NA LOOS	1						

			1 - For State	State of Ma		ertificate of		Mental Hygie	0000	0:000
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Tuncate of t	Dealii	Reg.	Net UU5	3. Time of Death
	Physic /Medi		Mabel	,	Smit	th		Month 19	^{Day} 2005 Year	2:p M
	Exami		4a. Facility Name (If not institution, give	,		4b. City, Town, or	r Location of Death		4c. County of Death	-I
			T.H.I. of Frank				timore		NA	
	Funeral Director	Г		- · · · · · · · · · · · · · · · · · · ·	(In yrs. last birthday) O Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11-14-)	ear) Cou	place (State or Foreign ntry)
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			T,	0d. Inside City Limits
	8a-f sho	Director	Md. N		-	timore				Yes 2 No
	th with the	al Dire	10e. Street and Number 1217 W. Fayette	Street		10f. Zip Code 2122	23	10g.	Citizen of What Cour USA	ntry?
920	i 72 hours after deeth with the Maryland "natural", or Itams 23a or 28a-f show after Fracility must be redified at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1	ean Indian, etc. ack
21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Healith and Menlal Hygene. Important: If item 27 Is marked other than "natur any injury or other traumatic event. In Medical Once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired OMEMAKET	during most of work	ing	. Kind of Business/In	dustry
nd 21	oe filed wall Hygier d other ti	Be Col	Unkn 17. Father's Name (First, Middle, Last)		111	omemaker	18. Mother's Name	e (First, Middle, Maid	Own Home	
Maryland	should but and Ment marked umaric c	To	Edward 19a. Informant's Name/Relationship (T)		ice	ing Address (Street a	Maude	al Route Number Ci	Bluford ty or Town, State, Zip	
e, M	1 and 2 Health a am 27 la		Loretta Rice 20a. Method of Disposition	Niece		02 W. Cold	dspring La	ane, Balt:	imore, Md.	21215
Baltimore,	Pages ment of I ant: If its ury or o		1 X Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		cemetery, cre	matory or other place mel Cem.	7–25-		Location - City or To undalk, Md	
Balt	permit. Depart Import any inj		21. Signature of Firm ral Service Licens Draw on Milk	290		2. Name and Addres March F.H		Baltimo	re, Md. 2 North Ave.	21202
F	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ATITER						Approximate Interval Between Onset and Death
	cate be executed was physician and physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):					
		edical		j						
.О. Вох	es that he death certility igned by the attending public detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
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T ;	ate h	Completed	os W					24a. Was an autopsy performed 1 Yes 2 V	prior to con death?	sy findings available indicate of 22 No
5 :	sicial certi irecto	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes 2 \(\text{No} \)	lospital:	- Con	Othor	26. Place of Death		77.	
on of	Attaining Frigstolans, or death. •ctor: After this certifically the funeral director, or the funeral director.	-	27. Manner of Teath 1 Natural 5 □ Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury	28c. Injury	at 2	ne 5 Residence 8d. Describe how in	6 ☐Other (Specify, jury occurred)
-	i i i i	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)		es 2 No	8f. Location (Street City or Town, Sta	and Number or Rural ite)	Route Number,
	within 24 hours af To the Funeral D completely filled in	edicai C	29a. Certifier (Check only one) (Check only one)	sician: To the best of r	kamination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause	(s) and manner as sta	ited.
4	within Fo the	Med	29b. Signature and title of certifier	and manner stated	J.	29c. License			ate signed (Month, D	
ľ	Δ		Mottlesse	M.D.		DOU 5	5457	丁し	1 LY 20	2005
	()		30. Name and address of person who co	mpleted cause of deat		Print) TAW STRI	Et 7 61	ALTIMOR	E MD ?	1201
	Star Registra	.~	31. Date filed (Month Hay, 200) 200	5 34 Registrar's		W.				

		1 - For State Registrar	State of Ma		ertificate of L			giene Reg. No 2005	26027
/M	sician edical miner	4a. Facility Name (If not institute 88 Ginwood	seph A. Ste on, give street and number) Lane		4b. City, Town, or Essex		th	21 2005 4c. County of Dea Baltir	3\coppm nore
Fune Direc		5. Social Security Number 215-12-0017 Usual Residence of Decedent	6. Sex 7. Age 1 X M 2 ☐ F	(In yrs. last birthday 84 Yrs.	Months Days	If Under 24 Hrs Hours Min	(Month Day	9,1921Ma	rthplace (State or Foreign ountry) Cyland
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene haturel; or Items 23s or 28s-1 show and the release and the state of the st	Director	10a. State 10b. Coun	ltimore	10c. City, Town or L	Essex			10g. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
ath with 23a or	ai Dir	88 Ginwood	Lane		10f. Zip Code 2122	1		USA	ountry?
5-0036 72 hours after des	by Funeral	3 ☐ Widowed 4 ☐ Divorce	If Yas Give	ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
ING 21215-UU35 be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. natural; or Items 23a or 28a-1 show	Completed	15. Decede (Specify only high Elementary/Secondary (0-12 1 2 t h	ent's Education lest grade completed) College (1-4or 5-	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired W Mainta	luring most of wo)	orking	Americar	•
E ag la b		George Ste	einbacher			Ida	Wrights		
Z 21 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2		Jean Jeppi	iship (<i>Type, Print</i>)		-			r, City or Town, State. re MD 212	
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item:		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other	n 3 □Removal from State	20b. Place of Disp cemetery, cre		9)	Date	20c. Location - City of Baltimon	r Town, State
Baltimol permit. Pages Department of Importent: If in	once.	21. Signature of Funeral Service	e Licensee Y	lli "	22. Name and Addres	. (yFuneralH timroe MD	NomeofEsse
Physici /Medic Examin	eal ner	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	the day Do not ere. a consideration of:	nter the mode of dying				Approximate Interval Between Onset and Death
Hecords, P.O. Box b8/60, The law requires that the death certificate be executed the has been signed by the attending physician and ages 2 should be detached for uses as the burial-transit	/Medical Examiner		c. Due to (or as a d. 23c. If yes, outcome c	a consequence of):				23d. Date of de	Nivery
at the death cert by the attendin	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
Records, P.O. In law requires that the delease been signed by the store 2 should be detached to	<u>۾</u> ا	Part II. Other significant condi	tions contributing to death bu	at not resulting in the	underlying cause give	n in Part I.		obacco use contribute t 'es 2⊟No 3□P	o the cause of death?
	amo	Cent	norg Are	fery	Disea	16	24a. Was a autop perfor 1 Yes	sy prior to	utopsy findings available completion of cause of s 2 \(\sum \) No
Of VITAL P Physicien: Th this certificate	o Be	examiner?	Hospital:	nt 2 ER/Outpatie	ent 3 DOA Othe	100	ath (Check only or	ne) lence 6 □Other (Spe	acify)
ding After	ation: T		28a. Date of Injun (Month, Day tigation	y 28b. Time	of 28c. Injury Work			ow injury occurred	,,
DIVISION ITEM ITEM ITEM ITEM ITEM ITEM ITEM ITEM	Certification:		mined 289. Place of inju- building, etc.				City or Tow		
LO IV To the Hospitel or A within 24 hours after To the Funeral Director of the Funeral Director of the Iventified in the Funeral Director of the Iventified in the Iventifie	edical	29a. Certifier 1 Certify (Check only 2 Medical one)	ring Physician: To the best of all Examiner: On the basis of and manner state	examination and/or i	th occurred at the tim nvestigation, in my op	e, date and place pinion, death occi	e, and due to the durred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
Total	2	29b. Signature and title of certification		٥.	29c. License		3	29d. Date signed (Mon. 7 22	th. Day, Year)
1		30. Name and address of person	1 LOH 11	2 4 M A	H. Print) CEAUE	, BAL	TIMOR	e Mo	21221
Red	State		32. Registr	rs Signature	Sourie	, ×			

Funeral Director

with the Maryland other then "naturel", or items 23e or 28e-f show vent, the Wedleal Examinatings be notified at filed within 72 hours after death Pages 1 and 2 should be nent of Health and Mental is marked nt of Health a ŏ

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner attending physician and for use as the burial-tran

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Jas certificate After this

State
State
Registrar amend item #17818 per fin 9845 7/22/68 tillicate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician SHEPPARD 5.30 AM Vancy. JUL 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** timore ONS VII Cate If Under 1 Year Marine 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
 Country) Months Days Hours Min 1□M 2AF 216-48-0675 Usual Residence of Decedent Yrs. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? á D2 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Co.e. e (1-4or 5+) DIVISION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANDREW CORPORAL SHEPPARD MARY HUCK. DUTT-19a. Informant's Name/Relationship (Type, Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheppard 28 Rider to 20b. Place of Disposition (Name of competery, crematory or other place) Kidae Date 20c. Lestion - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State permit. Pag Department Importent: if any injury o Cemetery rinity Joseph L Russ 21. Signature of Funeral Service Licensee Joseph L. Russ Fune 23a. Part / Enter the offease, or complications the serviced the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shippy, or heart fayure. List only one cause on each line. Approximate Interval Between Onset and Death sh cl, or heart fa u Immedia e Cause (Final disease or condition resulting in death) BRONCHO-PNEWMONIA week one Due to (or as a consequence of) Pulmonary obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine es Pirator Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 3 Probably 4 □Unknown 2 Paresis 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2: autopsy performed 1 🗆 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified . 30469 13 A Name and address of person who completed cause of death (Hem 23a) (Type, Print) Parkway & \$550. Co humbra Columbia: MD, 210 45 A 308, Veletoki 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		of Health and of Death	-	giene 005	24029
	Physici	an	1. Decedent's Name (First, Middle, Li	•				2. Date of De	ath Day Yea	3. Time of Death
	/Medi		Joseph Kenneth					July	19,2005	- 3:45 am
	Examir	ner	4a. Facility Name (If not institution, gi	• !		4b. City, Tow	n, or Location of De	ath O	4c. County of De	eath
				5 <i>pH1A(</i> Sex 7. Aq	e (In yrs. last birthday)	If Under 1 Y	ear If Under 24 H	rs 0 Data of Bi-		N. M. C.
п	Funeral Director		-	1⊠M 2□F	82 Yrs.		ays Hours Mi	n. (Month, Da		Birthplace (State or Foreign Country)
			Usual Residence of Decedent		02	1		July 7	,1923 Mai	yland
	the Marylan 28a-f show notitied at	_	10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Ba-f s	Director	Maryland Baltim	ore	Balt	imore				1 ☐ Yes 2 🖾 No
	or 2	Dire	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of What	Country?
	s 23s	ra	1420 Forest Park				1207		U.S.A	
	itams itams	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 1 Yes 2 □ 1		Was Decedent If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	- 14. Race - Ar Black, Wi	merican Indian, hite, etc.
920	hours after death with the Maryland tural', or itams 23a or 28a-f show M Exercitive trust be notitied at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2🏋	No Specify:		Specify:	White
9	27 68 53	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Oc	ccupation		16b. Kind of Busines	
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21	T T =	Co		2	P1	ant Man				e Telephone
and	be do do	Be	17. Father's Name (First, Middle, Las						Maiden Sumame)	
N N	d 2 should be f th and Mental I 7 is markad or traumatic eva	ဥ	George Schriefer	7.8 V			Ethel			
Maryland 21215-0036	カモトラ		19a. Informant's Name/Relationship						er, City or Town, State	
	s 1 and 2 if Health itam 27 i		Dorothy J. Schri 20a. Method of Disposition	erer (Wire	20b. Place of Dispo	sition (Name o	Park Aven	ue Balti Date		yland 21207
Baltimore,	ges It of If it		1 ☐ Burial 2 🛱 Cremation 3 [cemetery, crei	natory or other	place)		20c. Location - City of	
臣	outment cortant injury	Î	*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	2.2			atory 7-2	27-2005	Laurel, Ma	ryland
Ba	permit. Departm Importar any inju		hong	4 1/18	W	itzke F	uneral Ho	me of Cat	onsville,	Inc.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	pplications that caused	the death. Do not ent	er the mode of	ondson Av	e. Catons	sville, Mai	ryland 21228
J	rnysi ci an		Immediate Cause (Final	one cause of each lin	ne.				,	Interval Between Onset and Seath
	/Medical		disease or condition resulting in death)	aDue_b (\$\frac{1}{2}\s)	Consequence of	ra				mmus
	Examiner			Cin	Los C	MARK	10			11000
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					grans
6	and I-transi	Examiner	that initiated events	a 130	adder		men			Years
90,	be executed ician and burial-transit	Ë	resulting in death) Last	Due to (or as a	a consequence of):					8
8760	ate hys	dicai	•	d				-		
9 X	leath certific attending p	/Me	IF FEMALE:	02- 16						<u> </u>
Вох	atten atten for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregna			23d. Date of d Month	elivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time or death 5L	Other (specify	"			-4,
	The law requires that the de ite has been signed by the a rage 2 should be detached to	A P	Part II. Other significant conditions	contributing to death bu	it not resulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	quires than signed and lid be det	0							es 2 No 3 F	
Ö	w require been si should b	lete						24a. Was a	24h Were	autopov findings ovojlabla
Re	The law ate has page 2 :	Completed						autop	sy prior to med? death?	
tal	(0	0	25. Was case referred to medical				26 Place of Dr		2 1 No 1 Ye	s 2 No
Division of Vital	Phyaician: this certificatal director,	To B	examiner? 1 ☐ Yes 2 ② No	Hospital:	nt 2 ER/Outpatien	t 3 DOA	Other	eath (Check only or Home 5 ☐ Resid	ence 6 Other (Sp	acity)
0	ding Phys h. After this funeral di	ü	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of		njury at Nork?		ow injury occurred	BCHY)
<u>Ö</u>	death. ctor: Af the fu	atic	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigatio	n	injury		Yes 2 No			
Ξ	after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, stre (Specify)	et, factory, offi	сө	28f. Location (S City or Tow	treet and Number or F	Rural Route Number,
	ital curs af									
	Hosp 24 hor Funa fely fi	icai	Conock only 2 Medical Exal	nysician: To the best of miner: On the basis of	examination and/or inv	occurred at the	e time, date and place by opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner a	is stated.
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	Medicai	one) 29b. Signature and title of certifier	and manner stat	led.		ense number			
	8 48 4		CIANIA	= 110		_	- 4		29d. Date signed (Mon	and the same of th
	15		20 Name a setting of	completed and a city	-th (!! 00-) =	1 0	000020		PI preside	17007
	10		30. Name a address of person who	And	atri (item 23a) (Type, I	Print)	11091	990	SALARD	,9005 bw15,Mc
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	MAPLL	11102	1227	JUHIN Y	DU II-, MIL
10	Registra		.]111 9	2 2005	. L	1.				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 William Edward Seibert July 18 2:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richev Hospice N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 30, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 216-22-4557 Yrs Director 77 Usual Residence of Decedent the Maryland 10a, State 10b. County init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan carment of Heatth and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or Items 23s or 28a-1 show injury or other traumatic avant, Ire Madical Exams is must be mailised as 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Cathedral Street, Apt. 33 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No à Specify 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Stage Manager Baltimore Symphony 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Seibert. Schultz Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelien Seibert - wife 18 (05 701 Cathedral Street, Apt. 33, Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. * 4 ☐ Donation 5 ☐ Other (Specify) 7/19/2005 Beltsville, MD 21. Signature of Funeral Service Licenses CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD MO0986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung Cancer months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Pantil. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic obstructive pulmonary 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No. 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 Yes 2 No 2 0 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Wither (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manna of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DZ4170 ompleted cause of death (Item 23a) (Type, Print)
LEY Hospice 838 NEutaw St. Baltimore, MD 21201 Richer Hospice 2 2 2005 Registrar

amend item/23a(c), persion Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2005 Levada Hazel Smith July 17, 1605 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner al Center

7. Age (In yrs. last birthday)

Wrs

16 Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Country) | 1. Country)

Sept. 26, 1941 Tennessee Upper Chesapeake Medical Center 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 220-36-9696 Usual Residence of Decedent death with the Marylend 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28e-f show the Medical Examinar must be rediffed at Director 1 ☐ Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Flying Point Road 21040 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
like. DO NOT use religed)
Shipping & Receiving 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Administrator Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be f Health and Mental I Gurnie (nmn) Chadwell ဂ Ruby Iva Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i 3071 Ebbtide Drive, Edgewood, Maryland 21040 Kim Cowan / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ŏ 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdhs 7-21-05 Aberdeen, Maryland McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respisator Pnysician Exacerbahay /Medical Due to (or as a consequence of) Examiner reseen Upper Lobe wee a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed for use as the burial-transit Respiratory Failure that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the 9 Unknown NA à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records. Un controller TSCYes 2 No 3 Probably 4 Unknown Completed CFIF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? MA 1 Yes 2 No 1 Yes 282 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at NA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitei or Attending Injury 1 Natural 5 Pending N death. MA 2 Accident investigation 1 ☐ Yes 2 ☐ No efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HA To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062704 07-17-2005 PHYSICIAN 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kartik J. Desai MD Berair, MD 21014. Medical Chesapeake Courter 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 2 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 U 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 0040 AM SANFORD 2005 17 ンレレン /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner CITY BALTIMORE BALTIMORE CENTER JOHNS HOPKINS CARE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 14, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** VA (Country) 1 □ M 2 1 F 71 Director 236-48-2898 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 103 Center Place #306 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: t3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 P Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home unk and Mental Hygin is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna M. Wilson Jack Henry Huff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5505 Hopkins Bayview Circle Baltimore, MD 21224 Bayview Care Center Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a, Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
000ce. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street enny 11/100 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS FROM NON-HEALING ABDOMINAL WOUND **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 MONTHS HEMICOLECTOMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner MONTHS The law requires that the death certificate be executed ADENOCARCINOMA OF TEANSVERSE burial-trans Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No detached signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown DIABETES MELLITUS TYPE I Completed peen : CORONARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Płace of Injury - At home, farm, street, factory, office building, elc. (Specify) within 24 hours after To the Funeral Direct 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20063164 JULY 17 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 HOPKINS BAYVIEW CIRCLE SEIDHARAN BALT IMORE, ANIEUDH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

			For State Registrar	State of Mary	•	artment of l		Mental Hygi	ene	E 01000	
	Physici /Medic Examin	an al	Decedent's Name (First, Middle, Last) Alberta 4a. Facility Name (If not institution, give:		der	4b. City, Town,	or Location of Dea	2. Date of Death Month July	Day Y 14 2 4 6 4 c. County of		
			Union Memorial Hos			Balti		S O Date of Dist	1	ltimore City	
	Funeral Director		218 26 1296	7. Age (In 7.	yrs. last birthday 5 Yrs.	Months Days			⁹ 29	Birthplace (State or Foreign Country) Maryland	
	e Maryland 8a-f ehow	ctor	Usual Residence of Decedent		10d. Inside City Limits 1 X Yes 2 □ No						
	with the	Dire	10e. Street and Number 1254 Sargeant Stre	et et		10f. Zip Code	21223	10	g. Citizen of Wh Unit	at Country? ed States	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow air injury or other treumatic event, the Medical Enatural must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	in U.S. 13.		Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White	
Maryland 21215-0036	ithin 72 ho ne. nan "naturi Medical	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	(Giv.	DO NOT use retir	during most of wo	orking 1	6b. Kind of Busin		
d 21	filed w Hygier Sther th	Cor	17. Father's Name (First, Middle, Last)	N/A	Hon	nemaker	18. Mother's Na	ame (First, Middle, M	Own H		
/lan	Mental Mental arked c	To Be	Herman Birdges				Anna	a Needer			
	alth and 2 sho		19a. Informant's Name/Relationship (Ty Brenda Ault — Dau					Rural Route Number, t, Baltimo			
nore,	ages 1 a int of Hea t: if Item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of Imatory of other of YEN MENIOT K	fal o	Date 2 7/19/2005	20c. Location - Ci Glen B		
Baltimore,	permit. P Departme importan any injuri once.		21. Signature of Funeral Service Licens	99	Ŕ	2. Name and Add	ess of Facility G	ary Larkai iai Park vd., Elkri	ıfman Fu	neral Home at	
	Pnysiclan		23a. Part1. Enter the disease or complete shock, or heart failure. List only of immediate Cause (Final disease or condition	cations that caused the	-			ac or respiratory arre		Approximate Interval Between Onset and Death	
8760,	Medical Examiner bhysician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a co Due to (or as a co Due to (or as a co	nsequence of):						
.O. Box 6	death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	cy		23d. Date (,	
σ	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying cause g	iven in Part I.	23e. Did tob	20	o use contribute to the cause of death?	
of Vital Records	The law ate has b page 2 si	Completed	()					24a. Was ar autops) perform 1 Yes 2	prio ned? dea	ore autopsy findings available or to completion of cause of ath?	
Vita	Physician: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	at 20 004 0	ther	eath (Check only one		(Specific)	
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Division	o di più	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · building, etc. (S	At home, farm, s pecify)	treet, factory, office	9	28f. Location (Str City or Town		or Rural Route Number,	
	Hospitei 24 hours a Funerai steiy filled	dical (sician: To the best of m							
	To the P vithin 24 To the F complete	Med	29b. Signature and title of ceptitien	and manner stated.		29c. Licer	nse number	29	9d. Date signed (Month, Day, Year)	
\			1/1/			AT2	438946	6	July 16	12005	
	10		30. Name at that fess of person who c	ompleted cause of death	(Item 23a) (Type	Print)	norral H	spital	Mary	Month, Day, Year) 1 2455 and	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature,	Coule	- 170		(

			For State Registrer	State of Maryland	-	rtment of He		nd Me		ene	200	
П	Physici	an	1. Decedent's Name (First, Middle, Last,	egel					Date of Death Month	Day	Year _ 2.1	imeo Dentil
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of		Sella 1	4c. County o	Death	
ı	LXamiii		Baltimore Rehabilitat	TOP and Extended	Con	Center .		1+im			N/	A
	Funeral Director		EE0 E0 0010 /	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year 4 Months Days	If Under 2	Min. A	Date of Birth Month, Day, Y PR. 16,	1929	9. Birthplace (Country)	State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation					10d. In:	side City Limits
	Mary B-f sh	tor	MD BALT	IMORE	BALT	MORE					1[□Yes 2 No
	ith the or 28	Olrec	10e. Street and Number	•		10f. Zip Code			10g	. Citizen of Wi	,	
	s 23a	rai	6701 SAGINAW CIR		140.1	N - D	21209			14 Bass	US	
	iter de r Itam iner	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🕱 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 		Vas Decedent of His Yes, specify Cubar	n, Mexican,	Puerto Rio	can, etc.)		- American Inc White, etc.	
215-0036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	_ 1	☐ Yes 2 💢 No	Specify:			Specify:	WH	ITE
2	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation 10 e completed)	6a. Deced	ent's Usual Occupa kind of work done di OO NOT use retired)	tion uring most	of working	16	b. Kind of Bus	iness/Industry	
712	withir iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	CHEM]					AAI COF	RPORATI	ON
פ	ould be filed within 72 hours after death with the Marylan Mental Hygiene. Markad other than "natural", or Itams 23a or 28e-f show attic event, it a Marolical Examiner must be multiled at	Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name (F	First, Middle, Ma	iden Sumame)	
Maryland 2	should be filed within 72 hours after death with the Maryland and Mental Hygiene. rnakkad other than "natural" or Itams 23a or 28e-f show umatic event, It e Medical Examiner mate to natifie deal	ToE	SAMUEL	_	SIEG			SSIE			COHEN	
Mar	0 0 0 0		19a. Informant's Name/Relationship (Ty MARY LOU SIEGEL			g Address <i>(Str</i> eet a SAGINAW				•	·)
<u>ნ</u>	Health Health tem 27 othar tra		20a. Method of Disposition	20b. Place		sition (Name of natory or other place				c. Location - C		tate
ē	00		1 X Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	ienioval nom State		NUSACH AI		/21/2		ROSEDA	LE, MD	
_	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Licens			. Name and Address			LEVINSO			C.
10	207 2 2		/an/			000 REIST						
	e 11		23a. Part1. Enter the di lease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	o not enti	er the mode of dying	j, such as c	ardiac or r	espiratory arrest		Inten	oximate val Between et and Death
	Pnysician /Medical		disease of condition resulting in death)	Due to (or as a consequent		nia	-					Doins
	Examiner			Due to (or as a consequent	JO 017.							U
1	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):							
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):							
8760,	cate be executed bhysician and the burial-transit	cal E		240 (0) 40 4 00110040011	30 01).							
89	tificate ig phys as the	0		J						1		
Box	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel dea	ath 3⊡	Ectopic pregnancy				23d. Date Mont	of delivery h Day	Year
0.	ne dea the at	yslci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 🗆	Other (specify)				WOIL	п Бау	rear
J.	The law requires that the de ite has been signed by the a page 2 should be detached f		Part II. Other significant conditions con	ntributing to death but not resultin	g in the ur	iderlying cause give	n in Part I.		23e. Did tobac	cco use contrib	ute to the cau	se of death?
rds	w requires been sign should be	ed by	Alzheime	is Dimin	tion				1 🗆 Yes	2 □ No 3	Probably	4 🗷 Unknown
Vital Records,	e taw re has bee	Completed							24a. Was an autopsy	pri	or to completic	ndings available
		Con							performe	d? de	ath? ∃Yes 2□N	
<u> </u>	sicien: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	fospital:		Othe			Check only one)			
ō	g Phys er this eral dir	\vdash	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury 28t	o. Time of	28c. Injury Work	INUIS		5 Residence d. Describe how			
ioi i	tending Flaath. tor: After the funer	atlo	Natural 5 Pending investigation	(Month, Day Year)	Injury		? ′es 2□N	lo				
Division of	by by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f	f. Location (Stree City or Town, S	et and Number State)	or Rural Rout	e Number,
_	spitel ours a nerel C		29a. Certifier Certifying Phy.	sician: To the best of my knowled	ine death	occurred at the time	e date and	niace and	due to the caus	se(s) and man	ner as stated	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Exemi	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my op	inion, death	n occurred	at the time, date	and place, ar	d due to the ca	ause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License				. Date signed		
	4		1 DO HO	m. F	J .	000	055	203	5 3	My	19th.	2005
	σ_j		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type,	Print)	\triangle I	.4	12.11		. 1/1	71710
	Sta	ite	31. Date filed (Month, Day, Year)	ompleted cause of death (Item 23 32. Regigerar's Signature 2005	ULh	IS GVER	DIV	EX		TO COL) vno	L1 L10
	Registr		JUL 22	2005 Georges	K. J	goeste						

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** JULY 18, 11:28 A M SAUL MILTON Н. F. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4103 N. CHARLES STREET BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN. 17, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∏** M 2□ F 87 Yrs. 213-14-0950 MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show the Madical Examiner must be notified at 1 ¥ Yes 2 □ No Director BALTIMORE N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4103 N. CHARLES STREET 21218 USA Funeral filed within 72 hours after death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ LAW ATTORNEY 12 should be filed w h and Mental Hygier 7 is markad other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Dep. rtment of Health and Mental Important: If Itam 27 is marked of any jury or other traumatic ev. 90st. SAIONTZ SAUL IDA ABRAHAM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 405 EAST JOPPA ROAD - #100 - TOWSON, MD 21286 AARON MARGOLIS / ATTORNEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 7/21/2005 BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTRIW LOG MURPINAUM Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MOISINGA 1 ☐ Yes 2 ☐ N 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 DV 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attanding 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier buch of. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEDIAS CEVELE WORK W. an aligar Price

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 2 2005

ORIGINAL

32. Degistrar's Signature

Р	lease Type or Prin	t in Black In	delible lnk.	Ensure A	I Copies A	re Legible.				
. For	State of Ma	ryland / Depa	artment of H	lealth and M	lental Hygid	ene				
State Registrar		Cei	rtificate of	Death	Reg	I. No.				
1. Decedent's Name (First, I Sharon L.	Middle, Last) Taylor				2. Date of Death Month	20 200	23 Time of Beats - 1130 A M			
4a. Facility Name (If not inst.	itution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea				
SINAI HOSPI	TAL OF BALTIMO	28	BALTIMO	DRE		n/a				
5. Social Security Number 216-52-4080	8. Date of Birth (Month, Day,) Feb. 16	9. Bir	thplace (State or Foreign ountry) MD							
Usual Residence of Decede	nt		1							
MD 10b. Co	ounty N/A	10c. City, Town or Lo		imore			10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number		··· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ··	10f. Zip Code		100	g. Citizen of What C	ountry?			
426 E.	. Randall Stree	t		2123	30	US	A			
11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am				
1 Never Married 2 3 Widowed 4 XDive	Married 1 ☐ Yes 2 ☐ ⚠ If Yes, Give	lo	1 ☐ Yes 2 🛣 No	Specify:	Tiloan, oto.,	Specify:	Black, White, etc. Specify: white			
	cedent's Education highest grade completed)		dent's Usual Occup	ation during most of work	ing 16	6b. Kind of Business	/Industry			
Elementary/Secondary (0-		lite.	DO NOT use retired clerk	i)	9	State	of MD			
17. Father's Name <i>(First, Mi</i> Linton E					e (First, Middle, Ma reda Whit					
19a. Informant's Name/Rela	ationship <i>(Type, Print)</i> aylor / Daughte:		_			City or Town, State,				
20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	ation 3 □Removal from State ner (Specify)	20b. Place of Dispo	sition (Name of matory or other place	ce)	The second secon	Dc. Location - City or	Town, State			
21. Signature of Euneral Se	Victor		2. Name and Addre Charles I 1501 East	Stevens	Funeral	Home, Inc	^C 21230			
shock, or heart failure.	se, or complications that caused . List only one cause on each lin	the death. Do not ent					Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)	a. SEPSI	a consequence of):					FIVE DAYS			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libeates of Figure)										
that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	livery Day Year			
Part II. Other significant co	enditions contributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?			

Physician /Medical Examiner

attending physician and for use as the burial-transit

ed by the a

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Director

Completed by Funeral

To Be

Physician/Medical Examiner

þ

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, if a Modical Exaction to the routile of an once.

CORONARY ARTERY DIABETES

OBESITY

DISEASE

24a. Was an autopsy performed? 2 12 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 3 Probably 4 Winknown

25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

27. Manner of Death 5 Pending investigation

6 ☐ Could not be

determined

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D41129

29d. Date signed (Month, Day, Year) JULY 20, 2005

Peter W. Cho, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surgeon M.D.

BALTIMORE, MARYLAND ZIZIS

PETER W. 31. Date filed (Month, Day, Year) State

JUL 2 2 2005



Registrar

SINAL HOSPITAL OF BALTIMORE

lyonne Whelchel Thompkins

		Please Type or Pr				•	_	
		State of N			Health and Me	ntal Hygier	ne	
		Registrar 1. Decedent's Name (First, Middle, Last)	CE	ertificate of		Reg. I	2005	24.03.7
Physic		Yvonne Whelchel	Thomokins	2		Month I	8 2005	300 A M
/Medi Exami		4a. Facility Name (If not institution, give street and number	7)	4b. City, Town, o	or Location of Death		4c. County of Deatl	h
r. Ky k	5 A	628 N. Eutaw Street apt		Baltim If Under 1 Year		Data of Birth	N	IA
Funeral Director		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Months Days	Hours Min.	Date of Birth (Month, Day, Yea PRIL //	ar) _ Co	nplace (State or Foreigr untry) ARYLAND
		Usuel Residence of Decedent					100 11	/
death with the Maryland ms 23e or 28e-f show	5	10a. State 10b. County	10c. City, Town or L			7 -1		10d. Inside City Limits 12€ Yes 2 □ No
the M	Directo	10e, Street and Number		10f. Zip Code	TIMORE C	100.0	Citizen of What Co	untry?
h with 23e or		628 N. EUTAWST. AP.	T411		21201		USA	7 ,
	Funeral	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Specil ban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	rican Indian,
NUSO burs after death with the Maryla rel', or Hems 23s or 28e-1 shov Examinar must be notilied at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1 ☐ Yes 2 🗷 No			Specify: BL	nav
ified within 72 hours after Hygiene, other then "neturel", or Ite		15. Decedent's Education	16a. Dec	edent's Usual Occu	pation	16b.	Kind of Business/l	
be filed within 72 hc tal Hygiene. d other then "netur	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	r 5+)		during most of working ad)			
iled w dygier therth		12 HTGRADE 17. Father's Name (First, Middle, Last)	1+0	OMEMA	18. Mother's Name (I		-	ME
yidilik lould be i Mental i warked o	To Be	MCARTHUR JOHN	WHELC	HEI	BEVER		HENDE	=RSON)
and M and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street	t and Number or Rural F	Route Number, Cit	y or Town, State, Z	Tip Code)
s 1 and 2 if Health if Health other tre		BEVERLY HENDERSON (MOTI	FER) 634	O MOSHE	R ST. BA	LTIHORE,	MD. 2	1217
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Dallillo permit. Pages Department of Importent: If i eny injury or once.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	KING M	EM PAR, 22. Name and Addre	K 07-2	5-05 10	DOD LAWN	MARYLAND
Depariment of the control of the con		L Juhich N.W.	Cleans ?	JP, 25/	ess of Facility BR H. FULTON	AVELLE	BALTO A	10,21217
		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final	ed the death. Do not en line.	nter the mode of dyi				Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or a	S a consequence of):	embolus				
Examiner		Sequentially list conditions,	hourbook	lebhi				
be is	iner	if any, leading to immediate Due to (or a cause. Enter Underlying	s a consequence of):	0	_			
ou, se executed sian and surial-transit	Examiner	that initiated events c	s a consequence of):	here office	ifse			
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certificate be refined by sicial and physicial as the burnse as the burn	Med	IF FEMALE:						
wrequires that the death certificate be ex been signed by the attending physician should be detached for use as the burial	lcian/Medic	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	□Ectopic pregnanc	ey .		23d. Date of deli Month	very Day Year
the de	Physic	1 Yes 2 No 9 Unknown 9 Unknown	at time of doubt					
requires that the een signed by the hould be detached.	by Pi	Part II. Other significant conditions contributing to death	,	underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w requires to been signed should be	ted	Tuberous science	267-8			1 🗌 Yes	2 № 3 □ Pro	obabły 4 □Unknown
The law ate has be	Completed	hypektenera				24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
n: The ficate rr, pag		andget's duese 25. Was case referred to medical	2			1 Yes 2		2 🗆 No
OI VICAL Physicien: 1 ribis certifical ral director, p	o Be	examiner? 1 Yes 2 Hospital: 1 Inpa	tient 2 ER/Outpatie	ent 3 DOA Ot	26. Place of Death (ther. 4 ☐ Nursing Home	(Althor	6 ☐Other (Spec	cifv)
ng Phy Iter this	on: T	27. Manner of Death 1	jury 28b. Time Injury	of 28c. Inju	ry at 280 rk?	d. Describe how in		7.
INISION Tor Attending after death. Director: After lin by the fune	icat	2 Accident investigation	nium. At hama form a		Yes 2 □No	Location /Street	and Number or Ru	ral Pauta Number
after after Direct Jin by	Certification:	4 Homicide determined 288. Place of 1 building,	njury - At home, farm, s etc. <i>(Specify)</i>	treet, ractory, onice	201	City or Town, St	ate)	rai noute ivuinber,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only 2 Medical Examiner: On the basis	t of my knowledge, dea	th occurred at the ti	ime, date and place, and	due to the cause	(s) and manner as	stated.
the H nin 24 the Fi nplete	Medical	one) and manner	stated.					
To To	-	29b. Signature and title of cedifier	m M	29c. Licen:			Date signed (Month	
n		30. Name and address of person who completed cause of	death (Item 23a) (Type	Print)	2011	0	-01-0	-us
		Kythleen Mittey MD	1501 We	of Mant	2944 Rught Are	Brthno	e MD =	11217
St Regis	ate		trar's Signature	land a				
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Arneita Tyree Physici		1. Decedent's Nan	ne (First, Middle, La Arneita		i iie oc	Tyree		2. Date of D	Reg. Ng 0 Death 11, Day 2005	3. Time of Death
/Medic Examin		4a. Fecility Name	(If not institution, given LEY AVE Number 6.5	re street and number, Sex 7. At	ge (In yrs. last	4b. City	Town, or Location of Dea	s. 8. Date of B	4c. Coun	ty of Death IA 9. Birthplace (State or Fore Country) Md
n the Maryland	or	Usual Residence of 10a. State	of Decedent 10b. County	A		own or Location Baltimo	re	7-1	0-20	10d. Inside City Lim
with the	ai Director	10e. Street and No 1240	Darley Av	venue		10f. Z	Code 21218		10g. Citizen of	f What Country?
er dea iteme	by Funeral		rried 2 Married	12. Was Decedent Armed Forces' 1 Tyes 2 1 If Yes, Give Year or Dates:	?	13. Was Dece If Yes, sp 1 ☐ Yes	dent of Hispanic Origin? (scrify Cuban, Mexican, Pue	Specify Yes or North Rican, etc.)	lo- 14. Ra Bl Spec	ace - American Indian, ack, White, etc. ify: Black
Ind 21215-0036 be filed within 72 hours after tal Hygiene. d other than "natural", or lie event, the Maccal Examina	Completed	Elementary/Sec	,			6a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of wase retired)	orking		Business/Industry
rland 2 uld be filed ' Mental Hygie riked other	To Be Co	12th gr 17 Father's Name Willian	(First, Middle, Last	R.	Jord				le, Maiden Suma	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft popartment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", or y injury or other traumatic event, the Madded Examise.	The second		Name/Relationship		er 20b. Place	630 E. 2	S (Street and Number or F 7th Street, one of		ce, Md.	n, State, Zip Code) 21218 1 - City or Town, State
Baltimor permit. Pages Department of Important: If it		1 Burial 2 4 Donation			ceme	etery, crematory or cison For	other place)	22/05 Balt:	1	Mills, Md.
	8	23a. Part1. Enter shock, or he	the disease, or contact failure. List only	plications that cause	d the death. E		F.H. East	1101 1	E. North	Approximate Interval Between Onset and Death
Physician /Medical Examiner be executed burial-transit sthe burial-transit	dical Examiner	Immediate Cause disease or condit resulting in death. Sequentially list of any, leading to locause. Enter Unc Cause (Disease chat inditated even resulting in death)	onditions, immediate derlying or injury	b. Due to (or as	ensive s a consequent s a consequent	ce of):	lerotic card	iovascul	lar dise	ase
O. Box 687 at the death certificate by the attending phys tached for use as the	Physician/Medica	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3 □Ectopic			1	oate of delivery Month Day Year
cords, P.	þ	Part II. Other sign	ificant conditions	contributing to death	but not resultin	ng in the underlying	cause given in Part I.		I tobacco use co	antribute to the cause of death?
Vital Reco nicien: The law re certilicale has ber	e Completed	25. Was case refe	prod to modical				00 Plus 4 P	1 Per	opsy formed? 2 \(\text{No} \)	Were autopsy findings availal prior to completion of cause of death? Yes 2 No
ivision of or Attending Physical Control of Interest of the funeral of the funeral distribution by the funeral dis	Certification: To Bo	examiner? 11 Yes 2 C 27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide	No ath 5 Pending investigation 6 Could not be	28a. Date of Inj (Month, Date of Inj	ury 28 ay Ye <i>ar)</i>	b. Time of Injury M	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	28d. Describe	sidence 6 💢O	
Hospita Punors Funoral tely filled	ledical Ce	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis and manner s	of examination	dge, death occurre and/or investigation	d at the time, date and place n, in my opinion, death occ	ce, and due to th	e cause(s) and n e, date and place	nanner as stated. , and due to the cause(s)
To the within 2 To the comple	Me	29b. Signature an	V	In			OCME		-	ned (Month. Day, Year) 12, 2005
let br.		30. Name and add	14. (UP)	Wer, NO			Penn Stree	t Balti	more, M	aryland 21201
Registr	ar	,	JL 2 2 200	5 Jean	, K	Sporte		o minera		

			1 - For State Registrar		Maryland /	Depa		of H	ealth a		lental Hy	_		21.020
	Physici	an	1. Decedent's Name (First, Middle, La	•							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medio		Mary Eleanor 4a. Facility Name (If not institution, giv		ər)		4b. City, T	own, or	Location o	of Death	July 1		ty of Deat	3:00 P M
	LXamii	101	Heart Homes of						ville				altir	
	Funeral		5. Social Security Number 6. S	Sex 7 □M 2120 F	Age (In yrs. last	birthday) Yrs.	If Under 1	Days	ff Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	-	nplace (State or Foreign untry)
	Director		219-16-9989 Usual Residence of Decedent		97	113.	ll				July 4	, 1908	Mai	ryland
	aryland show	_	10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	the Ma	Director	Maryland Baltim	ore	Timo	nium		2 1						1 ☐ Yes 2 🙀 No
	3a or		12330 Rosslare	Didao Po	na # 50	1	10f. Zip (2109:	2			10g. Citizen of		untry?
	ems 2	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.					gin? (Spe	cify Yes or No Rican, etc.)	- 14. Ra	ce - Amer	ncan Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23a or 28a-1 show event. It is Medical Existing a routiled at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2[ff Yes, Give Year or Date:	₹%∘		1 ☐ Yes 2		Specify:	, Pueno	nican, etc.)	Spec	ack, White	white
5-0	n 72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	(Give	dent's Usuaf kind of work	done du	tion uring most	of worki	ng	16b. Kind of I	Business/I	ndustry
12	within iene.	omp	Elementary/Secondary (0-12)	Coflege (1-4c	or 5+)		<i>00 NOT</i> use p ly C]		Tuni	c+		U.S.	Corror	annon+
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yla	should be nd Menta marked	To	William Theodo							hia		Cully		
Maryland	d 2 sh th and th and 17 Is m traum		19a. Informant's Name/Relationship (Stephen T. Taylo											onium, MD
	f and feal		20a. Method of Disposition		20b. Place		sition (Name				ate	20c. Location		
Baltimore,	permit. Pages Department of H Important: If ite any injury or ot		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		10	_	Cemet			-21-	05	Perrym	an. M	Maryland
3alti	permit. Pa Departmen Important: any injury		21. Shin ture of Funeral Service Licer	isee (1		-				e, P.A.			ar j rana
ï	₫ Ω 5 6 8		230 Bort Sporthadianna grann	nas Per	Must	1,	317 Cc	kes	oury	Road	, Abino	gdon, M	aryla	and 21009
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	o not ent	er the mode	or aying,	, such as o	cardiac o	r respiratory ai	rest,		Approximate Interval Between Onset and Death
	Frrysician /Medical		disease or condition resulting in death)	a. Due to (or a	as a consequence	e of):								24 hours
h	Examiner		Sequentially list conditions	b										
	ed sit	Juer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of a jury)		as a consequenc	e of):								
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequenc	e of):								
8760,	te be (ysiciar e buri	ical		d										
89)	artifica ing ph e as th		IF FEMALE:											
Вох	death certifica a attending pla of for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 ☐ Fetaf dea at time of death		Ectopic pre						ate of deliv	rery Day Year
P.O.	at the de by the	ysic	1 Yes 2 Pro 9 Unknown	9☐ Unknown		5	Other (spe	спу)						•
S, D	es that the death igned by the atte be detached for	by Pl	Part II. Other significant conditions of	ontributing to death	but not resulting	in the ur	derlying cau	use giver	n in Part I.		23e. Did to	obacco use con	tribute to	the cause of death?
ord	w raquire baen sig should b	ted	dementia,	2010191	y and	ery	dis	iea	se,		1 🗆 Y	′es 2□No	3 Pro	bably 4 □Unknown
Sec.	e taw i has b	Completed	colonic ine	rtia,	054201	201	0515				24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
al	ician: The lav certificate has rector, page 2		25. Was case referred to medical								1 Yes	med? 2 X No	death? 1 🗌 Yes	2 🗆 No
<u> </u>	ysicia s certi directo	o Be	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital:	tient 2 ER/0	Dutpatien:	1 3 DOA	-			(Check only o ne 5 ⊡ Resid		ner (Sneci	my Assisted Live
Division of Vital Records,	ding Phys h. After this funeral di	T :uc	27. Manner of Death 12 Natural 5 Pending	28a. Date of In (Month, D	jury 28b	. Time of		c. Injury a Work?	at			ow injury occur		7
Sio	ttendi death. ctor: A / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 🗆 N					
Div.	after of Direct In by	Certification:	4 Homicide determined	289. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, stre	eet, factory,	office		2	8f. Location (S City or Tow	Street and Numi m, State)	ber or Run	al Route Number,
	To the Hospital or Attending Physician: The taw requires that the death certifica within 24 hours after death, within 24 hours after death. To the Funestal Director: After this certificate has been signed by the attending pit completely filled in by the funeral director, page 2 should be detached for use as to		29a. Certifier 1 Certifying Ph	ysician: To the besi	st of my knowled	ge, death	occurred at	the time	, date and	l place, a	nd due to the	ause(s) and m	anner as s	stated.
	the H hin 24 the F nplete	Medicai	one,	niner: On the basis and manner:	stated.	and/or inv				n occurre				
,	Mit Vois		29b. Signature and title of certifier	~~/	1 - 40		290.	License	number	0.0	4	29d. Date signe	od (Month,	Day, Year)
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type I	Print)	V	711		1	40	70)
			Ted Hork	7825	Yorl	2 P	d. 7	احم	ء س	on	MD	212	04	
	Sta	- 3	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature									
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 19, 2005 Margaret ₿. Turner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 1055 W. Joppa Rd. Apt. 718 Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs. Director 215-18-6946 1922 17, Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exeminar must be mailfied at 1 Yes 2 No Director Md. Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road Apt. 718 21204 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Depertment of Heelth and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic event, Inst. 2006. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry D. Belt Margaret S. Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret T. Hardy/Daughter 14 Farnham Way Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 17/23/05 Baltimore, Maryland 21. Signatur Funer I Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 ai complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Opset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** 0100 disease or condition resulting in death) Ach /Medical Due to (or as a consequence of) Examiner Satisfies the satisfies of the same of the satisfies of t Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 2 Fetal death 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No ۴ 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) >. Mclonne 6301 Willia 31. Date liled (Month, Day, Year) 32. Registrar's Signature State JUL 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7005 2, Louise Tillman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Battore
Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) St. Agnes Hospita If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖸 F 87 Director Dec 28, 1917 Maryland 215-24-0492 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Evantiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a 21228 1502 Frederick Road USA Funeral 14. Race - American Indian, Black, White, etc. unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Iter any injury or othar traumatic evant, The Medical Examinat once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 Caton Avenue Baltimore, MD 21229 St. Agnes Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
`4 ☐ Donation 5 ☑ Other (Specify)in state 21. Signature of Funeral Service Licensee Ronald S. Marie, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INKNOWN INT-ARCTON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): ir any, teading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ng physician and as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 ☐ No be detached the Ö 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 within 24 hours after death. To tha Funaral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) AGNES HOSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Black B. Registrar JUL 2 2 2005

			1 - For State Registrar	State of M				of H	eaith a		ental Hy	giene Reg. N2 (24042
	Physici /Medi		1. Decedent's Name (First, Middle, I	TAI							2. Date of De Month	18	200	
_	Examir Funeral	ner	4a. Fecility Name (If not institution, g Howard County 5. Social Security Number 6	General Ho	spita] last birthday)	Col1	umbi 1 Year	If Under 2		8. Date of Bin	How		n oplace (State or Foreig
	Director		220-31-5323 Usual Residence of Decedent 10a, State 10b, County	1 ∑ M 2□F	74	Yrs. y, Town or Lo	Months	Days	Hours	Min.	8. Date of Bir (Month, Da AUG • 1.	2, 193	0 0	China 10d. Inside City Limits
	the Maryia 28a-f sho	Funeral Director	MD Howard 10e. Street and Number			ridge	10f. Zip	Code				10g. Cîtîzen	of What Cou	1 Tyes 2 No
	ath with	raiDi	6104 Kara's Wal					2107					SA	
036	72 hours after death with the Maryland natural', or items 23a or 28a-f show uteal Examinet must be notified at	þ	11. Marital Status 1 ☐ Never Married ZX Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1	?]No	· ·	Was Decede If Yes, speci		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		Race - Amer Black, White ecify:	
21215-0036	f within 72 ho piene. r than "natur rhe Mcdical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		5+)	(Give	dent's Usual kind of work DO NOT use	k done d	furing most	of workin	ng		of Business/l	ndustry
land 5	be filed ntal Hyg od othe event,	To Be Co	/ 17. Father's Name (First, Middle, La Qing Dian Tang	st)		Owne	r		18. Mother		(First, Middle,	Frami Maiden Sur		
, Maryland	d 2 sh th and th and 7 Is m traum	-	19a. Informant's Name/Relationship Robert Tang - so			6304	Ruxto	n Di	cive,	Elkr	Route Number	MD 2]	L075	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	city))	Place of Disponentery, cremesapeal	ke Cre	m.,	Inc.	7/2]		Belt	on-City or T	e, MD
Bal	Depar Impor any ir		21. Signature of Funer Barvice Lic	ensee		Gai 725	y L. 0 Was	Kaui	man F gton E	uner 31vd.	cal Hom , Elkr	e@Mea idge,	dowrig MD 2	dge MP, Inc. 1075
	Pnysician /Medical Examiner		23a. Part1. Enter the diserse, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. META Due to (or a	line. SNAF	nic					JC & C			Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate date. Each Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a										
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	Ideath 3□	Ectopic pre Other (spe					23d.	Date of delive	very Day Year
Vital Records, P	The law requires ate has been sign page 2 should be	Completed by P	Part II. Other significant conditions Nov Mar Pro PSCU TO N1	sesnes	but not resi	•	nderlying ca	_		<u>u</u> S.	1 1 24a. Was autor	res 2 No	o 3 □ Pro	the cause of death? bably 4 Unknown copsy findings available completion of cause of
Vita	sician: certific rector,	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	iont 2	ER/Outpatien	nt 3 🗆 DO/	Othe	ar-		(Check only o		Other (Spec	(64)
ion of	Attending Physic death. actor; After this by the funeral di	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D	ury	28b. Time of Injury		lc. Injury Work		2	8d. Describe I			197
Division	i e i	Certification:	3 Suicide 6 Could not determine	building, e	etc. (Specify	v) 					City or Tov	vn, State)		al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled is	edical	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	Physician: To the bes eminer: On the basis and manners	of examinat	wledge, death tion and/or in	n occurred a vestigation,	t the tim in my op	e, date and inion, death	l place, a n occurre	nd due to the d at the time,	cause(s) and date and plac	manner as a	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature/and title of certifier	V. /	//		29c.		number 845	-2		29d. Date sig	gned (Month,	
•	Y		30. Name and address of person who	o completed cause of		1 23a) (Type,		05	55	UI.	TTLE L, M		N425.	8, 2005 T PKW
	Sta Registr	ite	31. Date filed (Month, Day, Year)	32. Regis	var's Signa		Soule	ر د		-911	3-1 101	70	- N- O	-,-,-

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2:57 A^M July 20. 2005 Underwood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Lorien Nursing Home If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 □ M 2√2 F 89 Yrs. 235-14-1909 Director May 24, 1916 West Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Modical Examination ast by notified at Columbia 1 ☐ Yes 2/0XNo MD Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21045 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2% No If Yes, Give Year or Oates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, If a Mule once. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper DGS Warehouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unavailable) Anne William Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6103 Dry Leaf Path, Columbia, MD Bill Vance - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/2005 Ahatomy Gift Registry Hanover, MD * 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc 21. Signature of Funeral Service Ligensee Zan 5555 Twin Knolls Road, Columbia, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lis Jass or 1, July) that initiated events resulting in death) Last Due to (or as a consequence of) Examine Sit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. ician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached Physi 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by å 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2 10 No 1 Yes 2 **X** No 1 Yes Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attanding P affer death. Director: After t Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a To tha Funaral L tha Hospital 29a. Certifig 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Chec and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign ture and title of certifie 00060160 30. Name and address of perso npleted cause of death (Item 23a) (Type, Print) RIVER NECK RS; PALTIMORES, Med 201-109 31. Date filed (Month, Day, Year JUL 32. Regimrar's Signature Year) State 2 2005 wer to from Registrar

Territarian State of Maryland / Department of Health and Mental Hy Certificate of Death 1. Decedent's Name (First, Middle, Last) SHERYL A. VENEY State of Maryland / Department of Health and Mental Hy Certificate of Death	Reg. No. 2 0 5 2 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2
1. Decedent's Name (First, Middle, Last) 2. Date of De Month CHERYL A VENEY	Day Year 3. Time of Death Year 7: 30 A M 4c. County of Death N/A
Physician SHEDVI A MENEY	4c. County of Death N/A
meanadi	N/A
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SINAL HOSPITAL () F BATIMURE BALTIMURE CITY	th 9 Birthplace (State or Foreign
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi	
Director 214 – 68 – 3465	/1963 MARYLAND
10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 4571 DERBY MANOR DRIVE 21215 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.	10d. Inside City Limits
MD N/A BALTIMORE CITY 106. Street and Number 107. Zip Code	10g. Citizen of What Country?
4571 DERBY MANOR DRIVE 21215	
4571 DERBY MANOR DRIVE 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Merital Status 11. Never Married 12. Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or Never Neve	D- 14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)	
GARLAND MARSHALL 19a. Informant's Name/Relationship (Type, Print) VIKIA VENEY / DAUGHTER 20b. Place of Disposition (Name of Date Operator) computers of other place)	
VIKIA VENEY / DAUGHTER 4571 DERBY MANOR DR., BY 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date Comparison 3 Democratifican State	20c. Location - City or Town, State
	PIKESVILLE, MD
	FUNERAL HOME 21207
23a. Arti Envir the isease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory a not, or hear failure. List only one cause on each line.	rrest, Approximate Interval Between
Physician Imm dia! Cause (Final dise is or condition STROKE	Onset and Death
/Medical resulting in death) Due to (or as a consequence of): EXDD CARDITIS	5 DAVS.
Sequentially list conditions, in any, leading to immediate Due to (or as a consequence or).	7 01143
Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
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d d d d d d d d d d d d d d d d d d d	
Solution of pregnancy 1	23d. Date of delivery Month Day Year
9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
5 5 6 A TNTRAVENOUS DRUG ARICE	obacco use contribute to the cause of death? Yes 2 \(\sum \) No 3 \(\sum \) Probably 4 \(\sum \) Onknown
The law re defines to the law red	
A the state of the	psy prior to completion of cause of death?
Telipatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesi	dence 6 Other (Specify) how injury occurred
27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Natural 5 Accident investigation 28c. Injury at Work? 1 Yes 2 No	
27. Manper of Death 27. Manper of Death 28. Date of Injury 28. Time of Injury 28. Tim	Street and Number or Rural Route Number, wn, State)
29a. Certifier Check only Check o	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the course of the time, date and place, and due to the course of the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time,	29d. Date signed (Month, Day, Year)
Dannit M.B. B.S. RES-000	TULY 20 . 1000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	50 0
DARSHANA PURUHT, M.B.B.S. SINAT HUSPITAL State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	UF BALTIMORE

State Registrar

JUL 2 2 2005

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland	-	irtment of tificate of		nd Menta		ene a. No.		
	- Physici /Medio		1. Decedent's Name (First, Middle, Last)	eral					Mo	te of Death onth	200	5,	7:00 A M
E.	Examin		4a. Facility Name (If not institution, give s Country Garden		ing		4b. City, Town,	or Location of ghland			4c. County of	Death Ward	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min (M	te of Birth onth, Day, 1	(ear) 1923	Birthp Coun Turl	place (State or Foreign plry) key
	a-f ahow	ctor	Usual Residence of Decedent		10c. City,		cation					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28 at be no	al Director	10e. Street and Number 12752 Scaggsville	Road			10f. Zip Code	207	77		g. Citizen of Wh urkey	at Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28e-f ahow apply injury or other traumatic avant, the Modical Examinar must be notified at anone.	Completed by Funeral		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		1 11	Vas Decedent of Yes, specify Cui	ban, Mexican,	in? (Specify Yo Puerto Rican,	es or No- etc.)	14. Race - Black, Specify:	White,	etc.
21215-0036	l within 72 ho iene. r than "natur tre Medicel	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			(Give life. L	lent's Usual Occu kind of work done OO NOT use retire	during most (of working	10	own ho		dustry
and 2	id be filed ental Hyg ked other c avant,	To Be C	17. Father's Name (First, Middle, Last) Muhsin Atakan						's Name (First		aiden Sumame)		
Maryland	nd 2 shoulth and Milh	-	19a. Informant's Name/Relationship (Type Mine Veral-Burke/d				g Address <i>(Str</i> ee Deer Tra						21042
Baltimore,	Pages 1 ar ment of Hea ant: If Itam: ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State			sition (Name of natory or other pl	ace)	Date	21	Oc. Location - C	ty or To	own, State
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8760,	Icate be executed from the physician and physician and physician strength and physician str	dical Examiner	23a. Pan1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or	e. Sa consequer a consequer	cles nce of):	rctic M	1			1,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pregnan	су			23d. Date Month		ery Day Year
۵.	quires that t n signed by uld be deta		Part II. Other significant conditions con	/ -	ut not resulti	ng in the ur	nderlying cause g	iven in Part I.	2:				he cause of death?
Division of Vital Records,	: The law require cate has been si page 2 should I	Completed								ia. Was an autopsy perform Yes 2	ed? pri	or to coo	psy findings available mpletion of cause of
ξ	sician s certifi lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 5€No	ospital: 1 □ Inpatie	nt 2□FE	VOutpatien	t 3 DOA	thor	of Death Chessing Home 5			(Specif	y) Assisted Liv
ion of	Attanding Physician: The Indeath. or death. ector: After this certificate haby the funeral director, page	atlon: To	27. Manner of eath 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		8b. Time of Injury	28c. Inj		28d. D		injury occurred		77 135 10 etc _ (V)
Divis	2 4 2 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At hom :. (Specify)	e, farm, str	eet, factory, office	•	28f. Lo	cation (Stre ty or Town,	eet and Number State)	or Rura	al Route Number,
	To the Hospital or Attant within 24 hours after death To the Funarel Director: completely filled in by the	edical (PSa Certifier (Check only one) Certifying Physical Examination	ner: On the best there: On the basis of and manner sta	t my knowle examination ted.	edge, daa# n and/or inv	restigation, in my	tima date and opinion, death	l place and Ju h occurred at t	ia to the cau he time, dat	ise(s) and mann e and place, an	er as ill d due to	tetad o the cause(s)
)	To t To tl	×	29b. Signature and title of certifier	le) (M	win 2	_ Uu	29c. Licer	362	46	29	d. Date signed	Month,	Day, Year)
			Robert W Olavie	mpleted cause of di	5 R	sesle	()	Gleu	Buri	nie h	10/2	10	60
	Sta Regista		31. Date filed (Month, Day, Year) JUL 2 2 2005	32. Registra	ar's Signatur	north !	•						

			State of Mary		rtificate of D			Res. N2. 0 0 5	24046
Chypinian	_	Decedent's Name (First, Middle, L		,			2. Date of Dea Month	Day Y	3. Time of Death
Physician /Medical		BRi	LE WILSON	/ 			JULY	14 200	- 00 0
Examiner		a. Fecility Name (If not institution, g	ive street and number)	2 - 4 /	4b. City, Town, or L			4c. County of	Death
	2	SOOD JAMARI	TAN HOSP	yrs. last birthday	If Under 1 Year	MOLE If Under 24 Hrs.	8. Date of Birt	h /	Birthplace (State or Forming
uneral		211 5	Sex 7. Age (III 1	Yrs. last billioay,	Months Days	Hours Min.	(Month, Day	y, Year)	Birthplace (State or Foreig Country)
irector	_	Jual Residence of Decedent	, ,	8	1		Smury	9/94/1	111:13:
MOI II	-	0a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limit
r 28a-f ehow	2	M.D N/G		BALAM	och E.				1 Des 2 □ N
r 288	3 1	0e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of Wha	at Country?
23a or ant be	a 2	2029 E. OlIVER	EL		21713			45.A	
r items 23a or 28a-f el drar must be rediffed Funeral Director	1	1. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No		American Indian, White, etc.
		1 Mever Married 2 Married			1 Yes 2 Ale			Specify:	477110, 010.
Esc.		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Black
event, the Medical Be Completed	2	15. Decedent's (Specify only highest g	Education grade completed)	(Gine	dent's Usual Occupati kind of work done du	ion Iring most of workir	ng	16b. Kind of Busin	ness/Industry
mp I	1	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			Thus SA	100 1
ther that		7. Father's Name (First, Middle, Las	2	1	hus Soles		/First Middle	Maiden Sumame)	is men
	ā				'				
the string and wenter hypothers than other than traumatic event, the Management of Be Comp		JESSIE WILSON		10h Mail	ing Address (Street an		Gold Number		ate Zin Code)
7 is n raun		19a. Informant's Name/Relationship	(Type, Print)	190. Maii	1		0		
item 27	1	a HELLINE BE 11 any 20a. Method of Disposition		20b. Place of Disp	esition (Name of		ate	MD HAY	
2 = 5	-	1 ☐Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	matory or other place))			
ortant: injury		`4 □Donation 5 □ Other (Spec		3 ARRISON	FOREST CEM	1/20	105	BM trinons	MD
Important: any injury once.	2	21. Signature of Funeral Service Lic	ensee		2. Name and Address				
1 = 0 0	+	Jamesa 73.	oth		129 N. CM			,	Approximate
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each line.	death. Do not er	nter the mode of dying,	, such as cardiac o	i iespiiatory ai	11631,	Interval Between Onset and Death
/sician	1	Immediate Cause (Final disease or condition	a DRAIN	CANC	ER				UNKNOWN
edical miner		resulting in death)	Due to (or as a co	onsequence of):					
	_ 5	Sequentially list conditions,	b						
st ine	1	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):					
burial-translt	Yall	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					
S C S									
dic the	2		d						
gned by the attending be detached for use as by Physician/Me	I MIC	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of	of delivery
for us	2	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2 ☐ 4☐Pregnant at tim	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Month	
by the tached	20	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ie oi deaui 3					
detac y Ph	Ē,	Part II. Other significant conditions	s contributing to death but n	ot resulting in the	underlying cause giver	n in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
		•	5	·	, , ,		10	Yes 2□No 3	Probably 4 Unknow
cate has been s page 2 should	<u> </u>						24a. Was	24b W/o	en autoney findings availab
has t	= -						autor	psy prio	ire autopsy findings available or to completion of cause of ath?
pag Cor							1 ☐ Yes	2 No 1	Yes 2□No
	ם	25. Was case referred to medical examiner?	Hospital:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Other	26. Place of Death			
actor Be		1 ☐ Yes 2 No	1 L Inpatient	2DER/Outpatie	ent 3 DOA	4 🗀 tvursing nor		dence 6 Other how injury occurred	
his certifi Il director To Be			28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	Work?	es 2 🗆 No	zau. Describe	now injury occurred	
Mer this certificance of the control		27. Manner of Death 1 Natural 5 ☐ Pending			M I		28f Location (Street and Number	or Rural Route Number,
Wher this certification on; To Be		Natural 5 ☐ Pending investigat	t ha	A4 b 6	t			um Ctata)	or Hural House Humber,
Mer this certificaneral director		Natural 5 Pending	be goo Bloom of Injury	- At home, farm, s Specify)	treet, factory, office	W.	City or To	wii, Statej	
Mer this certificance of the control	Certification;	Accident Suicide Homicide General Could not determine	28e. Place of Injury building, etc. (Specify)			City or To		
Mer this certificance of the control	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Ex	28e. Place of Injury building, etc. (Physician: To the best of raminer: On the basis of examiner.	Specify) ny knowledge, dea (amination and/or i	th occurred at the time	e, date and place, a	City or To	cause(s) and mann	
Wher this certification on; To Be	edical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending investigat 6 Could not determine	28e. Place of Injury building, etc. (Specify) ny knowledge, dea (amination and/or i	th occurred at the time	e, date and place, a nion, death occurr	City or Ton and due to the ed at the time,	cause(s) and mann date and place, and	d due to the cause(s)
wher this certification director on; To Be	Medical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injury building, etc. (Physician: To the best of n aminer: On the basis of ex and manner stated	Specify) ny knowledge, dea amination and/or i	th occurred at the time nvestigation, in my opi	e, date and place, a inion, death occurr number	City or Totand due to the ed at the time,	cause(s) and mann date and place, and 29d. Date signed (d due to the cause(s) Month, Day, Year)
Wher this certification director To Be	Medical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injury building, etc. (Physician: To the best of n aminer: On the basis of ex and manner stated	Specify) ny knowledge, dea amination and/or i	th occurred at the time nvestigation, in my opi	e, date and place, a inion, death occurr number	City or Totand due to the ed at the time,	cause(s) and mann date and place, and 29d. Date signed (d due to the cause(s) Month, Day, Year)
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Mer this certificance of the control	Medical Cermication;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending investigat 6 Could not determine	28e. Place of Injury building, etc. (Physician: To the best of n aminer: On the basis of ex and manner stated	ny knowledge, dea amination and/or i d. h (Item 23a) (Type	th occurred at the time nvestigation, in my opi	e, date and place, a inion, death occurr number	City or Totand due to the ed at the time,	cause(s) and mann date and place, and 29d. Date signed (d due to the cause(s) Month, Day, Year)

-04666		For	State of I	Maryland / De	partmen	t of H	lealth a	and M	ental Hygie	ene	
)	•	1- State Unpend Item	23a&27 p	er me G846	entinca?	e 67 9	Death			.n2005	24047
Physicia /Medic		1. Decedent's Name (First, Middle, Leroy Denni							2. Date of Death Month July 11	, ^{Day} 2005 Year	3. Time of Death O948 A M
Examin		4a. Facility Name (If not institution, g	ive street and number	er)	4b. City,	Town, or	Location of	of Death		4c. County of Dea	
42.00		1436 Hull Street 5. Social Security Number 6	Sex 7.	Age (In yrs. last birtho		timo	re If Under	24 Hrs.	8. Date of Birth		Tholace (State or Foreign
Funeral Director		212-72-8646	1 ⊠ M 2□F	38 Yrs	Months	Days	Hours	Min.	11/13/	1966	thplace (State or Foreign ountry) MD
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
Maryl -f sho	to	MD N/	A		Ва	lti	more	Cit	ty		1 XYes 2 □ No
ath with the Marylan 23a or 28e-f show	i Director	10e. Street and Number 1436 Hull St	reet		10f. Zip	Code		2	21230 10g	. Citizen of What C	USA
iteme iteme	by Funeral	11. Marital Status 1X_X9ever Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes X If Yes, Give Year or Date	X No	1 Yes			gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
72 ho	eted	15. Decedent's (Specify only highest of		(G	ecedent's Usua live kind of wo	rk done d	during mos	t of working	ng 16	b. Kind of Business	Andustry
within then the Max	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	e. DO NOT us W a	e retired ite				F	ood Servic
De fill H doth	To Be Co	17. Father's Name (First, Middle, La Leroy Wood	st)						(First, Middle, Ma		
	-	19a. Informant's Name/Relationship Randi L. Do								City or Town, State,	Zip Code) rland 21090
Saltimore, lemit. Pages 1 and Department of Healt mportant: If Item 2 inty Injury or other 105.		20a. Method of Disposition 1 Burial XX remation 3 4 Donation 5 Other (Special Control of Control		te Bayvie	sposition (Namere and Crematory or	ne of ther place mat	ory		ate 20 13/05	c. Location · City or Baltimo	
Baltimore Dermit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Fun (2) S., inc. Lic		r Doda	22. Name an Charl	d Addres .es	s of Facilit L. S	teve	ens Fune	eral Hom timore M	le, Inc.
€ 4		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that causely one cause on each	the death. Do not	enter the mod	e of dying	g, such as	cardiac or	respiratory arrest	,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ensive card	diovasc	ular	dise	ease			Onset and Death
Examiner		Sequentially list conditions,	b								
uted	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Otte to (or	as a consequence of):							
ate be executed hysician and the burial-transit	dicai Examin	that initiated events resulting in death) Last	C. Due to (or :	as a consequence of):							
= 0 a			. 0.								
C. BOX 62 The death certific the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pro 5 □ Other (spo					23d. Date of de Month	livery Day Year
igne bed	2	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying ca	ause give	en in Part I.				the cause of death?
he lay	Completed								24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of
VITAL Ician: T Certificat ector, pe	Be	25. Was case referred to medical examiner?							(Check only one)		
Physic rthis c	0	1 Yes 2 No 27. Manner of Death	Hospital: 1Inpa	ntient 2 ER/Outpar					ne 5 Residence	e 6 Other (Spe	cify) at scene
on ding th. After	E C	1 Natural 5 Pending 2 Accident investigati	(Month, L	Day Year) Injur	y M	Bc. Injury Work 1 🔲 Y	ai ? /es 2∐1		od. Describe now	injury occurred	
DIVISION I or Attending after death. I Director: After d in by the func	ertification;	3 Suicide 6 Could not determine	d 289. Place of	Injury - At home, farm, etc. (Specify)	street, factory	, office		2	8f. Location (Stree City or Town, S	et and Number or Re State)	ural Route Number,
	edical C	20a Certifier 1 Cartilying (Check only one)	hydician: To the beaminer: On the basis and manner	st of my knowledge de of examination and/or stated.	auth occurred to investigation,	at the ter in my op	3 date an pinion, deat	d place a	nd due to the caus d at the time, date	e(c) and manner as and place, and due	to the cause(s)
To th withir To th comp	Σ	29b. Signature and title of certifier	I m/.	1:4		OCM	E		Ju	Date signed (Mont.	005
	1	30. Name and address of person wh	mpleted cause of	f death (Item 23a) (Typ	pe, Print)	Pen	n Str	eet	Baltimor	re, Maryla	and 21201
Stat Registra	e	31. Date filed (Month, Day, Year)	20 Desi:	Acrela Ciamatura							
DHMH 17 Rev 1/200	CE/	JUL 2 2	2005	www JF	a port						

VI.IV			State of Maryland / Department of Health and M 1 - State Amend Item#5 per FH G845 7/22/05 rtfficate of Death	ental Hygier Reg. I	ne no2005	24048
	2 1 45%		Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		NORMAN SYLVESTER WILEY JR.	JULY 18	3, 2005	12:24P M
	Examin		4a. Facility Name (If not institution, give street and number) 20 HIGH SEAS COURT 4b. City Town, or Location of Death ESSEX	•	SALTIMORI	
1	Funeral Director		5 Gard Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes MARCH 29,	9. Birth Cou. 1956 MA	place (State or Foreign ntry) RYLAND
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
	d aho	ō	MARYLAND BALTIMORE ESSEX			1 ☐ Yes 2 No
	r 28a	Director	10e. Sifeet and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
	h with	D E	20 HIGH SEAS COURT 2122	/	U51	7
	ame	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
5-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Itame 23e or 28e-f ahow any Injury or other traumatic event, the Madical Examinat must be notified at ance.	by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:		Specify: BL	9C/L
5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ng 16b	. Kind of Business/In	dustry
2121	han *	d L	Elementary/Secondary (0-12) College (1-4or 5+)	-	15 Arm	si mal
	Hygie Hygie thar t	ပိ	12 +H GRADE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid		SLITION
Maryland	d be sad o	To Be	NORMAN SYLVESTER WILEY SR. BARK	BARAT	EAN (1)	ARAFR
37	shoul nd Me mark	F	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rura	I Route Number, Cit	y or Town, State, Zij	Code)
	alth a		BARBARA WILEY (MOTHER) 833 W. PRATTST.	106 E	ALTO, M	5.21201
ore,	of He of He flem		comptony gramatony ar other place		Location - City or T	
Ē	Pag ment ent: b		4 Donation 5 Other (Specify) ARBUTUS CEMETERY, 7-2	5-05 AL	RBUTUS, A	IARYLAND
Baltimore,	permit. Depart Import any Inj once.		1. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 24. Dietuch N. Williams 25. Septiment Service Licensee	AVE.B	ALTO MO	21217
1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Interval Between
	Physician		Immediate Cause (Final disease or condition _ a _ CARBON MONOXIDE /NT	CXICAT	100	Onset and Death
^	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	LXammer	er	Sequentially list conditions, b. — Due to (or as a consequence of).			
4	ted	nine	cause. Enter Underlying Cause (Disease or injury			
6	be executed ician and burial-transit	Examin	that initiated events c			
8760,	cate be executed physician and the burial-transit	dicail	d.			
9		Medi	IF FEMALE.			-
Вох	death certifi e attending id tor use as	an/h	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv Month	ery Dav Year
	thet the death certified by the attending detached for use as	by Physician/Me	1 Yes 2 No 9 Unknown			
P.0	requires thet the een signed by the	P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ds,	signe signed be			1 ☐ Yes	2 10 3 Pro	oably 4 Dunknown
Records,	~ 0 to	Completed		24a. Was an	24b. Were auto	ppsy findings available
Re	has be 2	шc		autopsy performed 1 Yes 2	prior to co	mpletion of cause of 2 ☐ No
Vital	ician: Th certiticate rector, pag	0	25. Was case referred to medical 26. Place of Death		10 12163	20110
Ϋ́	S S	To B				y) AT SCENE
0	ng Ph Iter th neral		1 Natural 5 Pending (Month, Day Fear) Injury Work?	28d. Describe how in	P CARS :	BIECT
Division of	Attending r death. sctor: Atter	Certification:	22 Accident Investigation FUVA 7/18/0) 12/5/			
ivi	or Att	rtiff	28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	-	Al Route Number, H SEAS
	Hospitel	I Ce	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	(s) and manner as	stated.
	To the Hospitel or Attending F within 24 hours atter death. To the Funerel Director: Alter completely filled in by the funeral	Medical	(Check only one) 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and planner stated.	ed at the time, date	and place, and due	ò (ne ĉauŝė(s)
	To the within 2 To the complet	Me	29b. Signature and fille of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
			0.C.M.E	3	JULY 19,	2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		01001	
_)		MANYC. A. P. C. O. 111 PENN STREET, BALTIMORI	t, MAKYLANI) Z1ZUI	
	Sta		31. Date filed (Month, Day, Year) 32\$Registrar's Signature			
X 12	Regist	air	JUL 2 2 2005 Blow & Barrel			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 2005 1239 A M Golden L. Williams July 18, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/17/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Yrs. 88 Director Utah 528-14-9921 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exandmer must be codified at 1 X Yes 2 □ No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12400 Shelter Lane 20715 USA death 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 141-162 1 Never Married 2 Married or) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of College (1-4or 5+) Elementary/Secondary (0-12) Defense 4 Intelligence .. Pages 1 and 2 should be filed v iment of Health and Mental Hygis tant: If item 27 is marked other t jury or other traumatic event, to other! 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaye L. Williams/ Daughter 12400 Shelter Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 07/21/2005 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician -2 days OROBABL PINOMUSMY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a detached f Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. Completed by discose 1 Yes 2 No 3 Probably 4 Unknown ARteny 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Alzhernens direcse certificate 1 Yes 2 No To the Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertific mo 58289 - Maylord 7-19-05 10 lu ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UFFERLY Heecu 2001 Medical Center Parkway Annapolis, MD 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Blown & Lynds Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registre Reg. No.2 0 0 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** BRUCE HUGHES WHITENIGHT 5:05 P 2005 JULY 7, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SUNRISE OF COLOMBIA MARYLAND HOWARD COLOMBIA Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1**□**M 2□F Days Months 1914 PENNSYLVANIA Director 90 SEPT. 20. 189-09-6239 Usual Residence of Decedent per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. It a Martinal Experience. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No COLOMBIA Director HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21044 6500 FREETOWN ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. GOVERNMENT Coflege (1-4or 5+) Elementary/Secondary (0-12) DEPUTY DIRECTOR AGRICULTURE/ DEPT. 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LEAH REESE MATHIAS P. WHITENIGHT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 545 CLUBHOUSE DR. LOVELAND 80537 BRUCE J. WHITENIGHT - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State FALLS CHURCH, VA onation 5 Other (Specify) 7/10/05 NATIONAL MEM. PARK 22. Name and Address of Facility 21. Signat NATIONAL FUNERAL HOME 7482 LEE HIGHWAY FALLS CHURCH, VA 22042 Approximate Interval Between Ohset and Death 23a. Part1. Enter the disease, or composhock, or heart failure. List only of the death. Do not enter the mode of dying, such as cardiac or respiratory any Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 2 No 1 🗌 Yes 1 Yes or Attanding Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural Injury 5 Pending s after dea. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 037013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Little FATUXERY PARK WA 11.055 COLUMBIA MEDICAL GOTEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2 2005 Registrar

	1	State Amend It	em 1	State of per me	Aarylan 845 7	d / Depa Ce≀	rtment of I	lealth and Death	Mental Hyg	giene	000	21.051
Physician		1. Decedent's Name (First, M			Dwya		Wild		2. Date of Dea Month JULY 1	6. Day	. 0 0 J	3. Time of Death 2:42 PM
/Medical Examiner	4	ta. Facility Name (If not institu				TRAUMA		or Location of Dea			County of Death	
, Funeral Director		5. Social Security Number 213–29–4655	6. Sex			last birthday) Yrs.	If Under 1 Year Months Days			, Year)	9. Birth	place (State or Foreign intry) Md.
yland	_	Usual Residence of Deceden 10a. State 10b. Cou			10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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death with the Maryland ms 23e or 28e-f show return to notified at noteral Director		10e. Street and Number 2222 Cecil	Avenue	e			10f. Zip Code 2.	1218		rog. Ciliz	ten of What Cot USA	intry?
036 urs after pr, or its	2	11. Marital Status 1 Never Married 2 □ 1 3 □ Widowed 4 □ Divor	Married	12. Was Decede Armed Force 1 ☐ Yes 2X If Yes, Give Year or Date	s? DNo		Vas Decedent of Yes, specify Cub	an, Mexican, Puei	Specify Yes or No- rto Rican, etc.)		4. Race - Amer Black, White Specify: B1	, etc.
21215-0036 ed within 72 hours af ygiene. set than "natural", or in the Madical Exam Completed by F		15. Dece (Specify only hi	dent's Edu	cation com <i>pleted)</i>		(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wo	orking	16b. Kin	nd of Business/li	ndustry
2121 ad within /giene. er than " f. ine Mag	2	Elementary/Secondary (0-1	2)	College (1-4d	or 5+)		employed				NA	
and the file of other covent.	ם ב	17. Father's Name (First, Mid Angel	die, Last)		Foc	esa		18. Mother's Na	eme (First, Middle,		Sumame) Wild	er
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Baltimore, Mispermit. Pages 1 and 2 Department of Heelth a important: if item 27 is any injury or other tragonce.	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremat		emoval from Sta	te	emetery, crer	sition (Name of natory or other pla		Date		cation - City or T	_
Saltimore, semit. Pages 1 at Deportment of Hee mportant: if item any injury or othermore.	1	4 Donation 5 ☐ Othe 21. Signature of Funeral Sen	r (Specify)				em. Park . Name and Addr		22-05 Balt	imor	dallsto e, Md.	21202
Bal permi Deper impor impor any ir	-	Joseph	K. U	Valter	Ym	/		.H. East			North A	Ve.
Physician /Medical		23a Pah1. Enter the disease shock, or heart failure. Imhediate Cause (Final disease or condition resulting in death)	List only or	e cause on each	septime deat filine.	A Z	uush of	WOUL	ac or respiratory ar	rest,		Interval Between Onset and Death
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death cert death cert e attending of for use a sticlan/M	yaicidinim	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcor 1 Live birth 4 Pregnan 9 Unknow	2 Feta t at time of d	I death 3	Ectopic pregnand Other (specify)	гу		2	3d. Date of deliving Month	very Day Year
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Vital Records, sician: The law requires to certificate has been signe lirector, page 2 should be a Be Completed by	To local										24b. Were aut prior to c death? 1 Yes	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate ral director, pag	3	25. Was case referred to me examiner? ty⊒yes 2□ No		lospital:	atient 2 🗆	ER/Outpatrer	t 3 DOA	hor	eath (Check only of Home 5 ☐ Resid		☐Other (Spec	ıfy)
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Division c tal or Attanding P is after death. al Director: After t ed in by the funers Certification:			uld not be termined	28e. Place of building.	Injury - At h etc. (Special	ome, farm, str	eet, factory, office	sidace_	28f. Location (S City or Tov	Street and vn, State) Balf	Y 44 W	rei Route Number. Lifri 192 10
he Hospital on 24 hours at the Funeral Doletely filled in Adical Con		29a. Certifier 1 Cert (Check only one) 2 Med	ifying Physical Examin	sician: To the be ner: On the basi and manner	s of examina	owledge, deatl ation and/or in	occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within 2 To the complet		29b. Signature and title of ce	rtifier	h A	er-			C M E			signed (Month	
3		30. Name and address of per		mpleted cause of		п 23а) (Туре,	Print)		r, BALTIM			ND, 21201
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			Registrar	dlo (o at)		Oerui	icale of	Dealii	2. Date of Death	g. No.C. O U J	3. Time of Death
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	/Medic		Melvin		lling		O+ T-	. Landing of Book	July		
	Examin	er	4a, Facility Name (If not institution	on, give street and number	er)	1 40		Location of Death	1	4c. County of Dea	in au
1		Α	Hast Herita	age Nursin	ng (en	ter	Under 1 Year	If Under 24 Hrs.	9 Date of Birth	THRE	thplace (State or Foreign
	Funeral		5. Social Security Number	1 M 2 F	Age (In yrs. las		onths Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	ountry)
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	and and	Ì	10a. State 10b. Count	ty	10c. City,	Town or Locati	on				10d. Inside City Limits
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	ter death with Items 23e or	Funeral Director	1221 1176	Daning 1	_		210	1571		USA	
	ns 23	era	11. Marital Status	12. Was Decede	ont Ever in U.S.	13. Was	Decedent of H	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,
"	r Iter	필	1 Never Married 2 Ma	Armed Force arried 1 (es 2 [If Yes, Give	es? □ No		4.0		Rican, etc.)	Black, Whi	te, etc.
93	urs a		3 Widowed 4 □ Divorce	ed If Yes, Give Year or Date	s:	1 📗	Yes 2 No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland neturel; or ttems 23e or 28e-f ehow iteal Examinar must be notified at	Completed by	15. Decede	ent's Education		16a. Decedent	's Usual Occup	pation during most of work	ing 1	6b. Kind of Business	/Industry
218	within 7 ene. then "n	pie	Elementary/Secondary (0-12)	nest grade completed) College (1-4c	or 5+)	life. DO	NOT use retire	d)	,,,g		c 1
2	gien gien	Son	12			Clerk				rown ork	+ Seal
덜	be file tal Hy d oth	Be (17. Father's Name (First, Middle	e, Last)				18. Mother's Name	First, Middle, M	aiden Sumame)	
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Maryland	nit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. ortent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show injury or other treumatic event, the Medical Examinat must be notified at injury or other treumatic event, the Medical Examinat must be notified at a.		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing A	ddress (Street	and Numb r or Run	al Route Number,	City of Town, State,	Zip Code)
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Baltimore,	of He of Her	1	20a. Method of Disposition	2 DBomovol from Str	cer	ce of Dispositionetery, cremate	on (Name bf ory or other plac	сө)	Date 2	Oc. Location - City of	Town, State
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i E	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service	e Licensee	0	22. N	ame and Addre	ss of Facility	TIMORE	MD 2123	4
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			23a. Part1. Enter the disease,	or complications that causist only one cause on each	sed the death.	Do not enter t	ne mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Enysician		Immediate Cause (Final	st only did cause on each		D STO	46	Cirrhos	13		Onset and Death
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Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnan		topic pregnanc	.,		23d. Date of de	
	0 0	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	t at time of dea		her (specify)	y 		Month	Day Year
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σ,	requires that the	by P	Part II. Other significant condi		h but not result	ing in the unde	rlying cause giv	ven in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
Ę	w require been sig should b	pa k	DIABLI	RJ					1 □ Yes	s 2□No 3□P	robably 4 nknown
ပ္ပ	> 0 0	olet	Hypes	tension					24a. Was an	24b. Were a	utopsy findings available
Re	8 - 9	ompleted							autopsy perform	ed? death? No 1 ☐ Ye	
a	icien: Th certificate ector, pag	O e	25. Was case referred to medic	cal	<u> </u>			26. Place of Deat	1 ☐ Yes 2 h (Check only one		accisted
Division of Vital Records,		o B	examiner? 1 ☐ Yes 2 No	Uponital:	atient 2 E	R/Outpatient	3□ DOA Ct	200		nce 6 ther (Spe	ecity) Care
of	y Phys	-	27. Manner of Death	28a. Date of I		8b. Time of	28c. Injui Wo		28d. Describe how		
Ö	Attending Ir death. sctor: After by the funer	tio	1 Natural 5 □ Pend 2 □ Accident inves	ding (Month, stigation	Day 19ai)	Injury		Yes 2 No			
S	Attendir death.	ifice	3 ☐ Suicide 6 ☐ Coul	was in and 289, Place of	Injury - At hom	e, farm, street	factory, office		28f. Location (Str. City or Town,	eet and Number or F	lural Route Number,
ă	alor afte Dire	Certification:	4 Homicide	bullaing,	, etc. (Specify)				City of Town,	Siale)	
	spite hours mere y fille		29a. Certifier 1 ☐ Certify	ying Physician: To the be	est of my know	ledge, death oc	curred at the ti	me, date and place,	and due to the car	use(s) and manner a	s stated.
	ne Ho 1 24 I	edical	(Check only 2 Medic one)	al Examiner: On the basi and manner	is of examination r stated.	n and/or inves	tigation, in my o	opinion, death occur	red at the time, da	te and place, and du	e to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certific	- /I			29c. Licens			d. Date signed (Mon	
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	X		30. Name and address of person		of death (Item 2	23a) (Type, Pri					
	10		ALCOR	o spanus	615	· w.	MACI	040.11)e/ A/	MB 20	014
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1	Regist			2 2 2005	Professor o	Is So	we				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 13^{Day} **Physician** 2**00**5 1:25 рм PAULINE JANE WARNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 1937 **Funeral** Months Days Hours Min. 1□M 2√X Laurel, MD Yrs. 67 Director 219-38-6678 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State or 28a-f show traumatic event, the Medical Examiner number relitied at 1 ☐ Yes 2 ☑ 🔭 Director MD Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3455 Andrew Court 20724 Items 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, Item Martin and Once. Black. White, etc. 1 X ever Married 2 Married 1 ☐ Yes 2 XX o Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIII Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Industrial Towel Elementary/Secondary (0-12) College (1-4or 5+) Grade 9 Service Worker Supply, Inc. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Merson James William Warner 70 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3455 Andrew Ct. Laurel, Maryland 20724 Richard A. Warner nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Washial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 7/19/2005 Laurel, Maryland ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ply one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final Metastatic adenocarcinoma, unknown primary months Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No % Probably 4 Unknown Emphysema 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an was u. autopsy performed? Yes 211 No l as page 2 1 Yes 2 ₹ 1 ☐ Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2XX ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXIo in by the funeral dir Certification; To this 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of s after death. I Director: After t (Month, Day Year) Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a

To the Funeral I

completely filled pellil Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D 43237 July 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive Suite 102 Laurel, MD 20707 Paul Armstrong, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Color Is Aparle Registrar JUL 2 2 2005 DHMH 17 Rev 1/200

ORIGINAL

/Medical **Examiner Funeral** Director

the Maryland item 27 is marked other than "natural", or items 236 or 286-f show other traumetic event, the Mudical Examinar must be multied at of filed within 72 hours after de l'Hygiene. Other than "natural", or Item 1 and 2 should be filed with and Mental Hygien em 27 is marked other th Department of Health a Important: If item 27 Is any Injury or other tra

Baltimore, Maryland 21215-0036

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Physician /Medical **Examiner**

executed use as the burial-transit the attending physician certificate be þ signed to Physician: funeral director, this

Division of Vital Records, P.O. Box 68760, e Hospitel or Attending Pl 24 hours after death. e Funeral Director: After ti 24 hours a To the within 2

1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Years 17. Father's Name (First, Middle, Last) John L. Collins 19a. Informant's Name/Relationship (Type, Print) Husband Mr. Charles T. Walpole, Sr. 8340 Bletzer Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses uslin 7922 Wise Ave. oner Immediate Cause (Final Septicemia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical

State of Maryland / Department of Health and Mental Hygiene Rag. No. 2. Date of Death Day Year 2005 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death 7. Age (If yrs. last birthday) A /e If Under 24 Hrs. TIMORE SQUARE FRANKLIN 105 ed If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Days Hours Months 1 □ M 2 😡 F 67 Maryland Oct. 9,1937 219-32-6663 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8340 Bletzer Road 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, Whita, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Specify: þ White Completed 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna S. Zelenka 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 20c. Location - City or Town, State Sacred Ht. of Jesus Cem. 7/23/2005 Dundalk, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland and Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Examiner Physiclan/Medical 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28d. Describe how injury occurred Certification:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Dav. Year) 29c. License number

730063

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BAITIMORE Md SQUARE DR 9000 FRANKliN IUAR) Willes 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 2 2005

State

Registrar

(Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene

				itate of Ivia		Certificat		Death		eg. NO 11 5	21.055
	Physici		1. Decedent's Name (First, Middle, Last) Stephen Watson						2. Date of Deat Month	Day Year	3. Time of Death
	/Medic Examin		4a Facility Name (If not institution, give stre	et and number)			4t	. City, Town, or Lo		4c. County of Dea	ith
£	Exami	lei	Annapolis Nursing		b Center	c		Annapoli	S	Anne A	Arundel
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birtl	7 74 11	r 1 Year	If Under 24 Hrs. Hours Min.		, Year) C	rthplace (State or Foreign ountry) unk
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2√2 No
	e M	5	MD Anne Arun	del	An	napolis					
	ter death with the Marylan items 23e or 28e-f show iner must be notified at	Funeral Director	10e. Street and Number 900 Van Buren Str	eet		10f. Zip	p Code	21401	'	0g. Citizen of What Co USA	ountry?
020	ਤੂਰ ਲ	by	11. Marital Status unk 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	1_	13. Was Dece If Yes, spe		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	0	
21215-0020	within 72 hours ene. then "neturel", ne Medical Ere	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	on <i>mpleted)</i> College (1-4or 5		Decedent's Usu (Give kind of wo life. DO NOT u	ork done d	uring most of work	unk _{ing}	16b. Kind of Business	Mndustry unk
and 5	be filed tal Hygi d other	Be	unk 17. Father's Name (First, Middle, Last)			uı	nk	18. Mother's Nam	e (First, Middle,	Maiden Surname)	unk
Maryland	2 sh and is m raum	To	19a. Informant's Name/Relationship (Type,							r, City or Town, State,	
Baltimore, I	Pages 1 and nent of Health int: if item 27 iry or other ti		Annapolis Nursing 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 ☒ Other (Specify) j	oval from State	20b. Place of	900 Va Disposition (Na v, crematory or	me of		et Annap Date	Olis, MD 20c. Location - City o	21401 r Town, State
Balti	permit. Pag Department Important: i any injury o		21. Signature of Euroral Service Licensee Ronald S. Wa	7	ector	22. Name a State Baltim	Anato	my Board		Baltimore	Street
先	Physician		236. Pant. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused cause on each lin	the death. Do n	ot enter the mo	de of dying			rest,	Approximate Interval Between Onset and Death
	/Medical Examiner	her	Immediate Cause (Final disease or condition resulting in death) a.		Due to (or as a c		-	Vicus	1A)) 5	years
68760,	the death certificate be executed by the ettending physician end ached for use as the buriel-trensit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a c						
Box 68	eath certifica ettending ph I for use as th	-5	resulting in death) Last								1
o.	the death by the etter ached for	Physician/	Part II. Other significant conditions contril	outing to death bu	ut not resulting in	the underlying	cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
ords, P.	v requires that the de been signed by the e should be detached t	þ				1			24a. Was a		. Were autopsy findings available prior to completion of cause
of Vital Records,	Blaw has t	Completed							107	se 21/10	of death?
ita		Be	25. Was case referred to medical					26. Place of Dear	th (Check only or	ne)	
	Phys rthis araldi	ဥ	27. Manner of Death 1 Natural 5 Pending	pital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day			28c. Injury Work	4 Larivursing H		ence 6 Other (Sp.	ecify)
Division	or Attencester death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, fai c. (Specify)				28f. Location (S City or Tow	itreet and Number or F n, State)	Rural Route Number,
	To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 Certifying Physic (Check only one)	: On the basis of	examination and	l/or investigatio	n, in my of	pinion, death occur	red at the time, o	date and place, and du	ue to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	Que/2	rea	5	9c. License	number	_	29d. Date signed (Mor アレレリーネ	nth, Day, Year)
,			30. Name and address of person who com	eleted cause of de	eath (Item 23a) (Type, Print)	6vizi	Rd H	44 t/SU	29d. Date signed (Mor	20781
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	de					

DHMH 16 Rev 6/95

Clinton Young UNK 05-04799 05-04799 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

479	9		For	State of Maryland	•					01000
			State Registrar		Certii	ficate of L	Death		N2005	24056
**	Physici	an	1. Decedent's Name (First, Middle, Las	st)				Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Ulinton	Jour		h City Tours or	Location of Dooth	July 15	2005 4c. County of Dea	2341 P M
	Examin	er	4a. Facility Name (If not institution, give 627 North Pulas)			altimor	Location of Death		W/1	u i
	Funeral		5. Social Security Number 6. S		st birthday)	f Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		218-84-2891	BM 2□F 42	Yrs.	lonths Days	Hours Min.	9-21-1	162 Ma	ry and
pug	*		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locat	ion				10d. Inside City Limits
Manyla	ode i	5	MA		iltimo					1 XYes 2 □ No
death with the Maryland	28a-	rect	10e. Street and Number	2	LLII PAC	10f. Zip Code		100	. Citizen of What Co	
h with	13a ol	a D	2909 E. north	lun Karkwa	y	2/2	14		U.S. A	•
r deat	ist hygiene. d other than "natural", or itama 23a or 28a-f ahow avent, the Modical Expositive rount be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Wa	s Decedent of Hi es, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0036	, or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 KNo If Yes, Give	1 🗆	Yes 2. No	Specify:		Specify: B1	0.1
5-0036	itural al Ex		15. Decedent's E	Year or Dates:	16a. Deceden	t's Usual Occupa	ation	16	ib. Kind of Business	/Industry
1215 within 72	n 'n	plet	(Specify only highest gra Elementary/Secondary (0-12)		(Give kin life. DO	d of work done of OT use retired	during most of work	ing		
212	giene er tha	Completed	12	College (1-401 51)	P	acker			Sea Fo	od
12 g	id Mental Hygiene. marked other than matic avent, its M.	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, Ma		
Maryland d 2 should be file	Men	ျ	Eddie Your		10h Mailian	14 (04	Cora	Simmo	City or Town, State,	Tin Codal
Mai	th and		19a. Informant's Name/Relationship (Wpe, Print)		/- A/	orthern	Parking	Rald	LJ. 2121Y
re, r	f Health and Men Itam 27 is marke other traumatic		20a. Method of Disposition	20b. Pl	2709 ace of Dispositi	on (Name of		Date 29	c. Location - City or	
mor Pages	ent of at: If i		1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		ory or other place		26 200	Bulb. L	
altimore,	Department of Important: If i any injury or one		21. Signature of Funeral Service Licer		29. N	ame and Addres	s Facility	Fred Se	rvice P.	J .
m a	8 = 8		Carlow C.	Dandan	17	Bi Mc	ullest.	Balto.	ud. 212	.7
W.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications the caused the death one cause on each line.	. Do not enter t	he mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	ysician	0. 1	Immediate Cause (Final disease or condition	. Multiple of	unsh	ot W	ounds	>		Oriset and Death
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78		6	S - uentially list conditions.	b. Due to (or as a consequ	ence of):					
petr	ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
D, exec	un and ial-tra	Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
8760, cate be executed	physician and the burial-transit	dlcal		d						
c 68	ing pl	1 (1)	IF FEMALE:						1	
Records, P.O. Box 6 The law requires that the death certif	attending p	lan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3 □Ed	topic pregnancy	,		23d. Date of de Month	livery Day Year
o. \$	the ched	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∭Pregnant at time of de 9∭ Unknown	atn 5 U	ther (specify)		=====		
That I	signed by the a I be detached f		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the unde	ertying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds quires	n sigr uld be	d by						1 🗌 Yes	2 No 3 □ P	robably 4 Unknown
S W W	s been sig	plet						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Vital Records, sician: The law requires t	page 2	Completed						performe 1 Yes 2	d? death?	_
/ita	certificate rector, pag	Be (25. Was case referred to medical examiner?			l au		h (Check only one)		
of Vita Physician:	within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director.	၉	MYes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient		4 🗆 Nursing H	ome 5 Residen		ecify) at scene
Division of lor Attending Phys	After funer	lo	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year)	28b. Time of Injury	28c. Injun Worl	k? Yes 2 No	Suh e	t Sho	+
VISION	death ctor: /	flca	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho	me, farm, street			28f. Location (Stre	et and Number or	ural Route Number,
	s after	Certification:	4 Homicide	building, etc. (Specify	idenso	IK		637	Seth Pul	BKI DHEET
ospit	hours uners ly fille			nysician: To the best of my knowniner: On the basis of examinat						
Div To the Hospital or	within 24 hours after death To tha Funeral Director: completely filled in by the	Medical	one)	and manner stated.						
70	To con	2	29b. Signature and title of certifier	000		29c. Licens			I. Date signed (Mon.	
^	1		you U	m- Tollel	200	O.C.M	l.E.		July 16, 2	200)
17	1		30. Name and address of person who	completed cause of death (Item A - SI A I 32. Figistrar's Signal	1 Penn	Street.	Baltimor	e, Maryla	and 21201	L
	Sta	ate	31. Date filed (Month, Day, Year)	32. Figistrar's Signat	with do	ale		•		
***	Regist		JUL 2 2	2005 Alvers .	77					
			9654							

			1 - For Amend Item 19 Registrar AMEND ITEM	State of Mary a per dyr (I #19a PER I	1846 / Dep 1846 / 8-24 FH G846 @	artment of H 5-05 tas 5/102/1050(1)	ealth and M Peath)5	24057
ı	Physici		1. Decedent's Name (First, Middle, Last) Donna C. Your	0				2. Date of Dea		rear	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County of	Death	1.25
			Johns Hopkins Bayview Co. 5. Social Security Number 6. Sex	re Center	yrs. last birthday)	Balt mon	If Under 24 Hrs.	1224 8. Date of Birt	Baltine		lace (State or Foreign
	Funeral Director			M 2√2 F 85	Yrs.	Months Days	Hours Min.	(Month, Day Feb. 5	y, Year) , 1920	Coun Per	lece (State or Foreign try) nnsylvania
	land W		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	e Mary	ctor	Maryland Balt:	imore			Dundal!	ς			1 ☐ Yes 2 x ∑kNo
	with th	Director	10e. Street and Number			10f. Zip Code	21224		10g. Citizen of Wh United		
	death ms 23	Funeral	502 48th Street 11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	- 14. Race	Americ	an Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Madical Exercities traited to Indifficed at ODEs.	by	1 ☐ Never Married 2 ☐ Married 3√√Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2€XNo	Specify:	ricali, etc.)	Specify:	White,	nite
21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work	ing	16b. Kind of Busi	ness/Ind	lustry
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	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, e Shephe	Maiden Sumame)		
Maryland	should nd Mer marke marke	은	Glen Colyer	oe, Print)	19b. Maili	ng Address (Street a				ate, Zip	Code)
	and 2		Robert A. Colyer	(DIOCHEI)		West 5th				1704	
ore	ages 1 nt of He I: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	-	osition (Name of matory or other place Cemetery	θ)	Date DOS	20c. Location - C		wn, State Maryland
Baltimore,	mit. Parame parame portant rinjury		 4 □ Donation 5 ☒ Other (Specify) 21. Signatur of Funeral Service License 			Name and Address Duda-Ruck	1				
Ö	Depar Impoor		pertin a fo	ne		7922 Wise	Ave. Du	ındalk,	Maryland		L222
			232. Part1. Enter the disease a compli- shock, or heart failure. List only or Immediate Cause (Final	cations that caused the ne cause on each line.	n			or respiratory ar	rest,		Approximate Interval Between Onset and Death
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9	tificate g phys as the	ledical									
O. Box	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month		ny Day Year
S, D	res that ti igned by be detac	by Ph	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to th	e cause of death?
ords	w require been sig should b		distrition melli	tise				1 🗆 Y			ably 4 □Unknown
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Vita	ysicien: The tis certificate hadinector, page	Be	25. Was case referred to medical examiner?	ospital:	-5500	Othe	26. Place of Deat			(0)	
on of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Polatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	f 28c. Injury Work	4 Mursing Ho		dence 6 Other)
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, is	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, larm, st pecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number m. State)	or Rura	Route Number,
	Hospita 24 hours Funerei etely filler	edical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medicel Exemi	sician: To the best of money: ner: On the basis of exa and manner stated.	imination and/or in	vestigation, in my of	oinion, death occur	red at the time, o	date and place, an	d due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signatur, and title of certifier	1	1,20 1021	29c. License	number		29d. Date signed (Month, I	Day, Year)
l	./		Frace a.	Gorde	mo	D 38	5763	(July 1	9, 5	2005
	5		30. Name and address of person who all Grace A. Cordts M.	mpleted cause of death 0 5505 Hop	Kins Bay	IVIEW C	ircle,	Baltim	ore M	d:	21224
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	parke					

		4	1 - State Amend Item 5	State of A	laryland 843 7-2	(Depa	artment of H	lealth a Death	nd Mental Hy	giene	E 21.0E0
7	Physicia		1. Decedent's Name (First, Middle, L.		,				2. Date of De	Day Th	3. Time of Death Year 2 55 A.M
	/Medic	al .		Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De.							f Death
	Examin	er	NORTHWEST HOSPIT				RANDALL			BALTIM	IORE
	Funeral Director				Age (In yrs. last 92	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bir (Month, Da	1912	9. Birthplace (State or Foreign Country) MD
	pu "		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	ith the Marylar or 28a-f show	ō		TIMORE			IMORE				1 ☐ Yes 2 No
	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?
	th with 230 o	ai D	15-A WARREN PAR	RK DRIVE				2120	8		USA
	er death with the state of the	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show disel Exant permust be rolliked at	by F	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	1 X Yes 2 [If Yes, Give Year or Dates	_1 NO s:		1□ Yes 2🎇 No	Specify:		Specify:	WHITE
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21	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retired STANT MAN	d)		METROPOL	COMPANY LITAN INSURANCE
d 21	filed within Hygiene. Ither then "	e Co	17. Father's Name (First, Middle, Las			ASSI.	START PAR		's Name (First, Middle		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryia I Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28e-f shov other traumatic event, the Medical France count be rediffied at	To Be	LOUIS			YATE	MAN	MOLI	LIE		CHARY
Man	12 sho		19a. Informant's Name/Relationship				•		or Rural Route Numb - BALTIMO		
	ges 1 and t of Health If Item 27 or other tr		LOIS STEINBERG 20a. Method of Disposition	/ DAUGHTE	20b. Place	e of Dispo	sition (Name of		Date	-	City or Town, State
D I	0 0		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec		BETH		natory or other plac EMORIAL F		7/20/2005	RANDAL	LSTOWN, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee		22	2. Name and Addre	ss of Facility	SOL LEVIN		
8	#9 # # 9		Moles /	dum							E, MD 21208 Approximate
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6	and and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a consequen	ce of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		d							
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Вох	ath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 ☐ Fetal de at time of death:	ath 3[Ectopic pregnancy Other (specify)	у		23d. Date Mont	of delivery th Day Year
o.	the de y the a iched t	Physician/Me	1 Yes 2 No	9□ Unknown		11 5	_ Other (specily) _				
٦,	es that the death certific igned by the attending p be detached for use as	by Pt	Part II. Other significant conditions	contributing to death	but not resultin	ng in the u	nderlying cause giv				oute to the cause of death?
ords	w require been sig should b	ted	Acrose Jena	L INSU	MICHEN	101	1 17474	grave			B Probably 4 Unknown
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al		e Co	25. Was case referred to medical					26 Place	1 ☐ Yes	2 1 No 1	Yes 2 No
× ×	Physicien: r this certific ral director,	To Be	examiner?	Hospital: 1 Inpa	atient 2 ER	/Outpatie	nt 3 DOA Oth	ner	rsing Home 5 Res		r (Specify)
n of	ding Phys T. After this funeral di	Ju: T	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of It		b. Time o		ry at rk?	28d. Describe	how injury occurre	d
Sio	Attending r death. ector: Atterby the fune	catio	2 Accident investigat	h-a				Yes 2□N		(Street and Numbe	r or Rural Route Number,
Division of Vital Records,	after d Direct In by	Certification;	4 Homicide determine	288. Place of	etc. (Specify)	e, tarm, st	reet, factory, office			wn, State)	or nural noute Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C		aminer: On the basis	s of examination				d place, and due to the h occurred at the time		
	o the ithin 2 o the omplel	Med	29b. Signature and title of certifier	and manner	P. LI	¥ 4 0	29c. Licens	se number	20	29d. Date signed	(Month, Day, Year)
	->-0		* Klan	garage		MIL	05	4 2	88	July	1 1819 2005
	10)	30. Name and address of person wh	completed cause of	of death (Item 23	3a) (Type,	Print)	North	niver H	spital	Cardo,
	Sta		31. Date filed (Month, Day, Year)	. Al	strar's Signature	8	And to				
in	Regist	ar	JUL Z Z	, 2005	248 S.	1.	7.200				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year Physician July 3, 2005 Avedikian 1:00 A Elizabeth Baranian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 19, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 ☐ M 2 🛛 F 86 Yrs . 1918 114-03-5235 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 23a or 28a-f show ust be notified at 1 X Yes 2 □ No Director Maryland Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20814 4925 Battery Lane #301 U.S.A. Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) The Modical Examinar of permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Infortant: If tiem 27 is marked other then "naturel", or lier any injury or other treumatic event, the Worldal Exertir at 908. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Spacify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Asst. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iskouhi Hajian Kevork George Baranian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3712 Stewart Drive Chevy Chase, MD 20815 Richard Avedikian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2005 Metropolitan Crematory Alex., Virginia 9 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 Almis 1 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Intercerebral Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy death Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Ś signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ requires 1 Tes 2 No 3 Probably 4 Unknown Pneumonia been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospitet or Attending Pl 24 hours after death. e Funerel Director: After th 5 Pending investigation 1 XNatural M 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospite! within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier D42222 July 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 11119 Rockville Pike Rockville, M.D. 20852 M.D. Mubashar Choudry, 32. Registrar's Signature State Estim Registrar

State of Maryland / Department of Health and Mental Hygiene 1= For AMEND#26perMD7/7/05, DPS, McCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Physician $2\bar{3}$ 10:05 P M Marjorie K. Altmann June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5555 Friendship Blvd. #608 Chevy Chase Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Hours Min. 2, Yrs 1919 577-12-1535 85 Nov DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or them 27 is marked other then "netural", or Items 23e or 28e-f ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23e or 28e-f ehow Examiner must be notified at Yos 2 No Completed by Funeral Director MD Chevy Chase Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5555 Friendship Blvd. #608 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturany injury or other treumatic event, the Medical ones. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mcfall Kerbey Elizabeth Waite 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7208 Clarendon RD. Bethesda, MD 20814 Betty Ann Dower /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X remation 3 Removal from State July 6,2005 Alexandria Virginia Mt. Comfort 9 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Lice 5130 Wis. Ave. NW Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Colorectal Cancer 18months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscass or light) Due to (or as a consequence of) Examine be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Becords, P.O. Box 68760, O. Box in State of the state of attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 0 4 Pregnant at time of death 5 Other (specify) been signed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Heart Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimer's Dementia certificate has perform page mea? 2ὧ No 2□ No 1 ☐ Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 | Inpatient 2 | DOA 0 this After this funeral of 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide I Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) title of certifig 29b. Signature and D23783 MD June 24, 2005 dress of person who completed cause of death (Item 23a) (Type, Print) 15 Daniel J. Esposito MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, 32 Registrar's Signature Coarte State 2005 Registrar

			State of Maryland / D	epartment of F Certificate of			iene 9. 2 0 0 5	24061
			Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		ROSELLA BRENN	VER		JULY 5,		8:08 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of Dea	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days		8. Date of Birth (Month, Day, MAY 4,	Year) 1921 PENN	rthplace (State or Foreign country) ISYLVANIA
	Director	}	175-16-6880			TIAL 4,	1921 1111	BIBVANIA
	rland		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
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aryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 le marked other then "natural", or Items 23e or 28e-f show other treumatic event, the Medical Examination until be malified at	2	BENJAMIN SADOWSKY	Mailing Address (Street				Zin Code)
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	1 and Health em 27 other tr		20a. Method of Disposition 20b. Place of	Disposition (Name of			20c. Location - City o	
DO I	Pages nent of hand or o		1 X Burial 2 Cremation 3 X Hemoval from State	y, crematory or other pla TORAH CEME'		7. 2005	CARRICK	. PA
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89	ifficate g phy as the	Physician/Medicai						
ŏ	eath certific attending p for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnanc	ξγ		23d. Date of de Month	elivery Day Year
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Ö	Attending For death. ector: After by the funer.	atio	2 Accident investigation	M 1	Yes 2 No			
Division of Vital Records,	l or Attencafter deatl	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	urs af		29a. Certifier 1X Certifying Physicien: To the best of my knowledge	double converse at the t	ime data and place	and due to the or	auso(s) and manner s	us stated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter thi completely filled in by the funeral	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basts of my knowledge (Check only one) 2 Medical Examiner: On the basts of my knowledge (check only one) and manner stated.	d/or investigation, in my	opinion, death occur	rred at the time, d	ate and place, and du	e to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. Licen	se number	2	9d. Date signed (Mor	nth, Day, Year)
1	- ≯ - ō		Karry Al Muha Wi	> 0003	6758		JULY 6, 2	005
	7		30. Name and address of person who completed cause of death (Item 23a) ((Type, Print)				
_			BARRY G. SIMON, M.D., 5530 WISCONS		SUITE #80	0 CHEVY	CHASE, MI	20815
	Sta		31. Date filed (Month, Day, Year) 32. Engistrar's Signature	Angelle)				
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Maryland 21215-0036 Manella

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 0335 BLAIR 05 MARVELLE 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula ar 1 Year If Under 24 Hrs. gional Nedical Cente NICONICO 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Days Min Yrs. 79 MAY 10, MARYLAND Director 215-24-4316 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No DELAWARE SUSSEX SELBYVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 332 SUGAR HILL WAY USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify 3 Widowed 4 NDivorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 7. Deparment of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other treumetic event. The Media once. Elementary/Secondary (0-12) Cotlege (1-4or 5+) MEDICAL RECORDS CLERK HOSPITAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JAMES** S. **CROSS** SARAH **OWENS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 SILVERBARK CT., MILLERSVILLE, MD 21108 GEORGE A. BLAIR JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/05 * 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEM. BALTIMORE, MARYLAND of Pure ral Service Licensee 21. Signat 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part: Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, terval Between tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) the Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner 12 ath 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending investigation 1 atural To the nearman within 24 hours after death.

To the Funerel Director: A: death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 20441 of begin who completed cause of death (tem 23a) (Type, Print)
Keffetto Eastern Share in S 30. Name and address of

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, 9) (ear

32. Resistrar's Signature

2005

SAlisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005 **Physician** Sharon Denise 2:55 PM /Medical 4a. Facility Name (If not institution, give street and number)
909 South Belgrade Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Country)
Wash., DC 7. Age (In yrs. last birthday) 43 Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** Year 1961 Days Hours 1 □ M 2 🕅 F Director 120-56-3555 Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event. The Medical Examinar must be notified at 1 Yes 2 No NC Willow Springs Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Kay Falls Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural, or Iter any injury or other traumatic event. The Medical Eractinal once. 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Technician Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Inez Smallwood Willie E. Gorham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1104 Kay Falls Lane, Willow Springs, NC Kenneth A. Brown - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7/2005 🗋 Cedar Hill Cemetery Washington, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home won 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or windition resulting in death) Pnysician Metastatic Gastric Cancer /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 Yes 2√ No 3 Probably 4 Unknown Hepatic Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Tother (Spline le's Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: I or Attending Fafter death. 5 Pending investigation after death. Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D23743 July 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Ct., Greenbelt, MM 20770 31. Date filed (Month, Day, Year) State 0 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 3, 2005 6:30 A M WILLIAM Α. BRYANT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BETHESDA MONTGOMERY SUBURBAN HOSPITAL
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day.)

 Months
 Days
 Hours
 Min.
 1-17-25
 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Yrs. WILMINGTON, NC 80 Director 162-20-7509 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Ne Jeal Exertent into the Lotting at 1 **∑** Yes 2 □ No CAPITOL HEIGHTS Director PRINCE GEORGE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 U. S. A. 507 BALBOA AVENUE 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FEDERAL GOVÉRNMENT 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) POLICE 12TH GRADE SECRET SERVICE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LELIA McCLAMMY ALEXANDER BRYANT, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VANESSA B. RIDGEWAY-DAUGHTER UPPER MARLBORO, MD 20772 7311 GAMBIER DR. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-9-05 WASHINGTON, DC 4 □ Donation 5 □ Other (Specify) MT. OLIVET CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., DC 20002 Luch 23a. Part1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner **PNEUMONIA** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of) physicien 68760 Physician/Medical the use as IF FEMALE Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) _ P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ XXY Yes 2 No 3 Probably 4 Unknown Completed Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: X X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) dir 1 ☐ Yes XX No 70 Certification: 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending XX Natural 5 Pending investigation 1 | Yes 2 | No Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospitai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title M.D

A (20)

JUL 0 7 2005

CHONDRY,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

D42222

ROCKVILLE, MD 20852

JULY 3, 2005

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

1 2005

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended line 1/8 per fh/tlv 708/Micate of Death Ü 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Brubaker Bertie Ρ. 7:14 P 2005 Julv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ijamsville Frederick 3304 Big Woods Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2**K**) F Yrs June 20, 1920 Maryland Director 213-18-9310 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b County ir than "natural", or Items 23a or 28a-f show the Madical Exampler count be notified at 1 XYes 2 No Director Ijamsville Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21754 3304 Big Woods Road Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. Specify White If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) perriit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, In Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Kohler Minnie Koehler T. Hamilton Bussard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3304 Big Woods Road, Ijamsville, MD 21754 Glenn Brubaker / Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bush Creek Cemetery 6/9/2005 Monrovia, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Jumey Enter the dise se or complications that outed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Tist only one cause of mach line. Immediate Cause (Final Recurra eseprovasculon 6yrs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi the attending physiclan and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Selzure 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 5 X Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred tuneral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) After or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide filled in by 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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	3		30. Name and address of person who	completed car	use of death	(Item 23a) (T	Type, P	rint)		Cat	ens	L-ille,	M	0 2	122	8	
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/Med Exami		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h	4c. County of De	ath
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Director		Usual Residence of Decedent	A				1225 20		
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. It a Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2√2 No	spanic Origin? (S n, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	Black, Wi	nencan Indian, lite, etc. White
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ary shou and N	-	19a. Informant's Name/Relationship (T)			•			City or Town, State	Zip Code)
and		Peter L. Bush/hus			Shawnee		Finksburg	•	
altimore, mit. Pages 1 ar partment of Hea portant: If item; y njury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Sremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		sition (Name of natory or other place Cremation	1	1/2005	20c. Location - City of Hampstead	
Balti permit. Departm Importa any inju		21. Signature of Fundal Service Licens	699	22 P	Name and Addres	s of Facility eral Hon	ne and Ch	apel, P.A	• 21157
		23a. Part. Enter the disease, or comp	lications that caused the dea	th. Do not ent	412 Washi er the mode of dying	ngton Re	oad West	minster, I	Approximate
Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition		Mad	ine infa	celsa			Interval Between Onset and Death 72 hours
/Medical		resulting in death)	Due to (or as a conse	quence of):	11/100	ulon			Several
Examiner		Sequentially list conditions.	a. <u>Aluse My</u> Due to (or as a conse b. <u>Metastat</u>	ic lu	ng cance	_		,	Nontha
pe is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	J				
\$ 8760, icate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
8760, sate be e	dicai E	l	d						
68 tifficat ng phy as th	Medio	15 551111 5							
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
the degray the a	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5□	Other (specify)				,
IS, P.O.	y Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds quires and be	q pa	asthma					1 □ Ye	s 2□No 3	Probably 4 Unknown
Records, he law requires ti e has been signe	Completed						24a. Was ar autopsy	24b. Were a	utopsy findings available completion of cause of
	Com	1					perform	ned? death?	s 2 No
f Vital Rec ysician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	15		lou		ath (Check only one	9)	
a this	2	I Tes 2 No		ER/Outpatien		4 Nursing F	lome 5 Reside	nce 6 Other (Sp	ecify)
ding F	tion	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at :? /es 2 ∐No	28d. Describe no	w injury occurred	
Division of lor Attending Physafter death. Director: After this in by the funeral d	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, str				reet and Number or I	Rural Route Number,
Div	Certification:	4 Homicide determined	building, etc. (Speci	ny)			City or Town	, 3(4(9)	
Division of Vita within 24 hours after death. To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (sician: To the best of my kn iner: On the basis of examin- and manner stated.						
To the Within To the	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
WIL	1	Queishaan	NO		D00	62975		719105	
10		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)		C(- (C		2.16=
		19 Mei Sno	32. Regionar's Sign 2005	ature	ve. P30	1 We	strunst	er, MD	21157
St Regis	ate trar	. IIII 11	2005	K	hack .				
DHMH 17 Rev 1/		OOLII		1					

			State of Maryland / Department of Health and Mental Hygiene
			1- Stata Registrar Certificate of Death Reg. No. CUU5 24069
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death CRYSTAL JOANN BOWER 2. Date of Death Month Day Year THY 6 2005
	/Medic	al	CRYSTAL JOANN BOWER JULY 6, 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
1	Examin	er	1014 OLD MANCHESTER RD. WESTMINSTER CARROLL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		220-98-1463 1 1 M 254 39 Yrs. 7/17/1965 MARYLAND Usual Residence of Decedent
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Be-f sl	ctor	MD CARROLL WESTMINSTER 1□Yes 2XNo
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ne 23	eral	1014 OLD MANCHESTER RD. 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc.
9	or ite		1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No Specify: Specify: \$111 T □ E
21215-0036	within 72 hours after deeth with the Maryland ane. than 'natural', or iteme 23a or 28e-f show tha Madical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:
215	nin 72 n nai	plet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
212	filed with Hygiene. other ther	Com	11 SECURITY DISPATCHER ALARM COMPANY
Maryland	d ta b	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FREDDIE L. FERGUSON LINA LYNN WOOD
IZ.	2 should end Men is marka eumatic	은	19a. Informant's Name/Relationship (Type, Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 7
	and 2 selth e n 27 is		FREDDIE L. FERGUSON 30 LOCUST ST., APT. 609, WESTMINSTER, MD.
Baltimore,	permit. Peges 1 and 2 Depertment of Heelth e Important: If item 27 ii any injury or othar tre		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ē	it. Pertimentant:		*4 Donation 5 Other (Specify) ALL COUNTY CREMATION 7/11/05 SYKESVILLE, MD. 21. Signature of Facility FLETCHER FUNERAL HOME
Ba	permit. Depertrimportri		254 E. MAIN ST., WESTMINSTER, MD. 21157
	SHA		23a. Part 1 Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition _ a hand a g bineck (self induced _ minutes
	/Medical Examiner		resulting in death) Due to (or as a consequence of):
		er	Sequentially list conditions b. Due to (or as a consequence of):
	cuted nd ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):
760,	te be executed ysiclen and e burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):
687	~ > @		d.
Вох	h certi ending	In/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month Day Year
.O. B	The law requires thet the death certifica to has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1
<u>α</u>	res that the signed by be detacl	/ Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	quires an sign uld be	ed by	1 Yes 2 No 3 Probably 4 Unknown
000	iaw requir as been si 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of
Ä		Com	performed? death? 1 Yes 2 No 1 Yes 2 No
Vital	Physician: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred to medical examiner? Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
of	Z . S D	<u>⊢</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	Attending I r death. ector: After by the funer	atlo	2 Accident investigation 7-6-2005 1552 LMs 1 Yes 2000 Hong Selt
Division	or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
	spitei ours e nerel [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To t withi To tl	M	29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)
	MSV		DO05,924 July 7, 3005
	100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson J. My 2973 Manchester RJ Manches for MN 21102
	Sta	ate	31. Date filed (Month, Day, Year) 32. Relistrar's Signature
	Registi	rar _	JUL 1 1 2005 from to species

			For		aryland / Dep			Mental Hyg	giene						
			1- State Registrar Amend#26.Pe	erPhys.PG0	C 7-8-05 Ce	rtificate of	Death		leg. No. 20	05	21.070				
æ.	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3CTime of Geath				
	/Medi			a Briggs		4h Chi Tour	or Logation of Dog	June	30 20	005	6:35 P M				
4	Examir	ner	4a. Facility Name (If not institution, give		onital		or Location of Deal koma Park		,	ontgo:	moru				
			Washington Adv		SPILAI e (In yrs. last birthday						ce (State or Foreign				
	Funeral Director]M 2 X 1F	95 Yrs.	Months Days	Hours Min	Mar. 17	, Year) , 1910	Countr	orida				
	ס		Usual Residence of Decedent												
	nylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				100	d. Inside City Limits 1 X Yes 2 ☐ No				
	8a-1 s	octo	DC				Washir								
	vith th	Director	10e. Street and Number			10f. Zip Code	20000		10g. Citizen of W		•				
	s 23e	eral	1377 N. Caro	Lina Ave. 12. Was Decedent B		Was Decedent of I	20002 Hispanic Origin? (5	Specify Yes or No-		- America					
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it iam 27 is marked other then "natural", or Itams 23a or 28a-1 show or other traumatic event. Its Medical Examinar must be multipled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 XNo		to Rican, etc.)	Black Specify:	, White, et					
21215-0036	tural	edt	15. Decedent's Edu	cation		dent's Usual Occup			16b. Kind of Bus	siness/Indu	stry				
15	n 72 n "na	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5	life.	kind of work done DO NOT use retire	during most of world)	rking			•				
212	d with	E	12th	College (1-401 5		Laundry	y Technic	ian	(Gover	nment				
b	e filed al Hyg otha vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)					
/lar	should be nd Mental markad o	ToE	Edward Dixon					Li1	lian Tay	ylor					
Maryland	and 2 should be filed within 72 hours aft eath and Mental Hygiene. m 27 is markad othar than "natural", or mar traumail. or her traumatic evant. Its Medical Exami		19a. Informant's Name/Relationship (Ty Beatrice Molden			ing Address (Street 000 West			· ·	State, Zip C 20747	Code)				
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	Gem.	Date	20c. Location - 0	City or Tow	n, State				
Ë	Pages nent of I int: If itu		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	Washingto			3/2005	Suit1a	and,	MD				
alti	permit. Pag Department Important: any injury conce.		21. Sign was of Funeral Service Licens to 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019												
Ö	Depar Important any ir		John T. Sk	entery.		4001	Benning H	Rd., N.E.	Wash.,	DC 2	0019				
	Physician /Medical		23a. Par 1. Enter the disease, or compl shick or heart failure. List only of Immediate lause (Final disease in or indition resulting in death)	ne cause on each la	the death. Do not er e.	ter the mode of dyi	ng, such as cardia	c or respiratory ari	est,	i h	Approximate nterval Between Onset and Death				
,8760,	Examiner and instrument transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unseas or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	e Fla	ongert.	vie Leo	+ Failer	e)					
.O. Box 68	ie death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → Yes 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc	ey		23d. Date Mon	of delivery	ay Year				
٥	uires that th signed by Id be detac	þ	Part II. Other significant conditions co	ntributing to death be	ut not resulting in the	underlying cause gr	ven in Part I.		bacco use contri		cause of death?				
of Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autopoperfor	sy pr med? de	for to comp eath?	y findings available pletion of cause of				
ta		0	25. Was case referred to medical				26. Place of De	ath (Check only or							
\leq	Physician: this certific ral director,	To B	examiner?	lospital: 1 🗌 Inpatie	nt 25 ER/Outpatie	nt 3 DOA	her:	Home 5 Resid	ence 6 Othe	r (Specify)					
o uo	Attending Ph r death. actor: After th by the funeral	ition:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time (Wo	ry at ork?] Yes 2 □ No	28d. Describe h	ow injury occurre	d					
Division	affe Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, si c. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural I	Route Number,				
	To the Hospital within 24 hours of To the Funeral I	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the ourred at the time, o	ause(s) and mar late and place, a	ner as stat	ed. he cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier		0	29c. Licen:	se number	2	9d. Date signed	(Month Da	ay, Year)				
	0				-tu)	35826		6/.	0/0	<i>/</i> ,				
0	(1)		30. Name and address of person who ca	ompleted cause of d	eath (Item 23a) (Type	Print)	JJ020	7600	cam	110	ve				
-			Honacio	6	SCF	HAPIR	0 14	Tako	mer par	KM	10 20912				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	3 Registra	ar's Signature	acti									

			For State Registrar	State of M	1arylar	•	artment of I				giene Reg. No 20	05	21.07.
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath	UJ.	3. Time of Death
	Physici		EDDIE	LEE		BRO	WN			Month TULY	8 Day	Year	8:45 AM
	/Medic Examin		4a. Facility Name (If not institution,		r)	Dice	4b. City, Town,	or Location	of Death	2029	4c. County	of Death	
	LAGIIIII	CI.	MANOR CARE NUI				LARGO)			PRINC	E GEO	RGE 'S
	Funeral			5. Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	h 1916		lace (State or Foreign try)
	Director		247-20-0804	1 🖾 M 2 🗆 F	88	Yrs.	Months Days	Hours	Min.	Decembe	er 19	SOUT	H CAROLINA
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10a C	ty. Town or Lo	*:						0d. Inside City Limits
	show	-	,		100. 01							1"	1X Yes 2 □ No
	he M	Director		GEORGE'S		MITCH	ELLVILLE				10= Ciri(1)	Athen Cour	
	with t		10e. Street and Number	NA CIE			10f. Zip Code	1			10g. Citizen of \		try r
	s 23	Funerai	10812 GOLF TERI	12. Was Deceden	t Ever in II	IS 13 1	2072		igin? (Spec	ify Ves or No.	U.S.A	A. e - Americ	an Indian
	Item Item	Į.	1 ☐ Never Married 2 ☐ Marrie	Armed Forces	?		Was Decedent of If Yes, specify Cub	an, Mexicar	n. Puerto R	ican, etc.)	Blac	ck, White,	
39	urs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2 🕅 No	Specify:			Specify	ν: Β1	LACK
Š	72 hours after death with the Maryland Inatural; or Items 23e or 28e-f show dieal Examinat must be notified at	ted	15. Decedent's			16a. Dece	dent's Usual Occu	pation	4 -4	_	16b. Kind of B		
2	hin 7 e. an "n Med	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	kind of work done DO NOT use retire	adning mos nd)	it or working	g			
21215-0036	er th	Completed	6th			TAIL	OR				PRIVAT	ľE	
p	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Li								Maiden Suman IULDROW	70)	
yla	Men Men Marke	유	CHARLES	BROWN				LIL					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ita Madical Examinational be notified at once.		19a. Informant's Name/Relationshi				ng Address <i>(Str</i> ee GOLF TE						20721
	1 and fealth		CALVIN BF 20a, Method of Disposition	ROWN	20b. f		sition (Name of	KKACE	Da		20c. Location -		
و	in it		1 ☐ Burial 2 ☐ Cremation		е	cemetery, crer	matory or other pla					•	
Baltimore,	it. Partmer		* 4 □Donation 5 □ Other (Special Signature of Funeral Service)		Mt		et Cemet		7/19/0		Wadhing		
Ba	permi Depa Impo any ir		* A H	1.11	7				J		KINS FUN		
			23a. Part1. Enter the disease, or c	omplications that cause	ed the deat		474 LAND er the mode of dy					LAND	Approximate
	Di		shock, or heart failure. List o	nly one cause on each	line.								Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a		MOL	UI PT						
	Examiner				ME		A						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a									
	cuted	Examiner	that initiated events	c									
oʻ	e exe ian al urial-t	EX	resulting in death) Last	Due to (or a	s a conseq	juence of):							
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d									
9	eath certific attending p	Mec	IF FEMALE:	00. 1/									
Вох	ath o	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	il death 3□	Ectopic pregnand	у			23d. Dat Mo	te of delive: nth	ry Day Year
0		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time or d	ieath 5L	Other (specify) _						
ď.	res that the igned by th be detache	h h	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause gr	ven in Part I		23e. Did to	bacco use conti	ribute to the	e cause of death?
ds	Se 150	d by								1 🗆 Y	es 2 🗆 No	3 Proba	ably 4 ⊠Unknown
COL	w require been si should b	iete								24a. Was a	an 24b. \	Were autop	sy findings available
Record	0 - 0	Completed								autop: perfor	sy prod?	prior to com death?	pletion of cause of
of Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical					26 Place	of Death /	1 ☐ Yes Check only or		Yes	Z LXL NO
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	tient 2	ER/Outpatien	t 3 DOA Ot	205			ence 6 Othe	er (Specify)
0	g Ph er th		27. Manner of Death	28a. Date of In (Month, D		28b. Time of Injury		ry at			ow injury occurr		
jo	Attending r death. ector: After by the fune	atio	1 (XNatural 5 ☐ Pending 2 ☐ Accident investiga	tion	ay roar,	injury		Yes 2	No				
Division	I or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of II	njury - At he	ome, farm, str	eet, factory, office		28	If. Location (S City or Tow	treet and Numb n, State)	er or Rumal	Route Number,
	Ital or irs afte ral Dir led in	Cer											
	To the Hospital or Atterville (within 24 hours after de To the Funeral Director completely filled in by the	icai	(Check only 2 Medical E:	Physician: To the bes xeminer: On the basis	of examina	wledge, death	occurred at the ti	me, date an opinion, dea	id place, an th occurred	d due to the d d at the time, d	ause(s) and ma late and place, a	nner as sta and due to	ated. the cause(s)
	the the mplet	Medicai	29b. Signature and title of sectifier	and manner s	stated.		29c. Licen	se number			29d. Date signed	1 (Month)	Day Year
						- m	DDE	V/ C	17		JULY		-
	2 12 8	- 1					レールノつ	AID	,	_		0,0	
)	2		30. Name and address of person w	ho completed cause of	death (Item	n 23a) (Tune	Print)	0.0					3003
)	2)		30. Name and address of person w					nham,	Mary1				3003
	Sta	te	30. Name and address of person w Cecil George 31. Date filed (Month, Day, Year)	M.D. 8118		d Luck	Print) Road Lai	nham,	Maryl				

DHMH 17 Rev 1/2001

Registrar

		, For		artment of Health and M	lental Hygier	ne	
		1 - State Registrar	Ce	rtificate of Death	Reg. N	··2005	24076
Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	ay Year	2150 M
/Medic Examin		4a. Facility Name (f not institution, give street and number)	1	4b. City, Town, or Location of Death	<u> </u>	c. County of Death	
		Coastal Hospice WheLo	ike	Salisbury	(8:4	WICO	
Funeral Director		5. Social Security Number 6. Sex, 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea O 2 - 2 4 -		lace (State or Foreign htry)
		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or L	acation.	00.0.		Od. Inside City Limits
Aarylau f show	ō	Mb Worcester 5	only, rown or L	IJ., 17		'	1 XYes 2 No
h the h	irect	10e. Street and Number	1000	10f. Zip Code	10g. (Citizen of What Cour	ntry?
ath witi	raiD	502 S. Church St		21863		4.5.1	7
If E 12.15-0000 filed within 72 hours after death with the Maryland Hygiene Hygiene Tratural; or Items 23a or 28e-f show ent, it is Marylaal Exam her must be mailfied at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	U.S. 13.	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
ours af	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify: Bh	ACK
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation I kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Ind	,
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yidalid Alia buld be filed with Mental Hygiene, arked other the	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	en Sumame)	
should be filed within of Montal Hygiene. I marked other then manic event, the Montal Hygiene.	٩	19a. Informant's Name/Relationship (Type, Print)	19b Mail	ng Address (Street and Number or Rura	P. ZLS	or Town State Zin	Code)
ING 2 state of the contract of		Bernadine Tuntorthugh	/ / / /	LA. Stevens St	-Sam H		21863
es t and 2 of Health If Item 27 or other tr			Place of Dispo			Location - City or To	wn, State
Pag Thent ent: I		`4 □ Donation 5 □ Other (Specify)	oringt	111 Mengados	112/05- 14	ebrow	and thou
permit. Pa Departmer Importent any injury		21. Signature of Funeral Service Licensee	9	2. Name and Addres of Facility	el Cl	to the	D(80)
		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dying, such as cardiac of	or respiratory arrest,	dy me	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	tie		nces	,	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a cons	equence of):				
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icuted nd transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
of CC, rate be executed physician and the burial-transit		resulting in death) Last Due to (or as a const	equence of):				
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the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	death 5[Other (specify)		MOITH	Day Feat
that the the the the the the the the the th	by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
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law re nas be e 2 sho	Completed		· <u>-</u>		24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of
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ttendi death. stor: A	icati	2 Accident investigation 3 Suicide 6 Could not be	home farm st	M 1 Yes 2 No	28f. Location (Street	and Number or Rura	l Route Number
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fospite t hours unera	edicai (29a. Certifier Certifying Physician: To the best of my k	nowledge, deat	th occurred at the time, date and place,	and due to the cause	(s) and manner as st	ated. the cause(s)
thin 24 thin 24 the formplet	Med	one) and manner stated. 29b. Signature and title of certifier)		29c. License number		ate signed Month, i	
8 4 8 4		Je Uf UL	IM	D7627		17/05	:
200		30. Name and address of person who completed cause of death (It	em 23a) (Type	D7627 Print) Scalist	111	16-3	
	•	31. Date filed (Month, Day, Year) 32. Figistrar's Sig	70×1733 nature	Salist	MB 7	1102	
Sta Registr		31. Date filed (Month, Day, Year) 32. Figistrar's Sig	D. 19	facilis D			

			For State Registrar	State of Ma	ryland		artmer rtificat			and M		Reg. No. 2	005	21.075
	Physici		1. Decedent's Name (First, Middle, La Mary Catherine	_							2. Date of De. Month	Day	Year	3:Fime of Death 7
7	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location o	f Death	DULY C		ty of Death	0:30 A
			Salisbury Rehab 8					alist	oury				comico)
	Funeral		5. Social Security Number 6. S	ex 7. Age □ M 2 X F 90	(In yrs. la	ast birthday) Yrs.	Months Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt 7—17—1	h Year)	9. Birthp	
	Director		221-09-6516 Usual Residence of Decedent	90		113.					/-1/-1	714		Md.
	yland		10a. State 10b. County			, Town or Lo							1	0d. Inside City Limits
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ဗ္ဗ	eal', o	ρ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 X No	Specify:			Speci	^{ify:} Wh	ite
21215-0036	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	kind of wo	ork done d	uring most	of worki	ng	16b. Kind of I	Business/Inc	dustry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)		no Not i	·)			Garmen	t Co	
	filed Hygie Hygie other I	ပိ	9 17. Father's Name (First, Middle, Last)		Sean	ISCIE	55	18. Mothe	r's Name	(First, Middle,			
an	lid be ental ked c	To Be	Walter Thomas Wo	rkman					Rowe	ena l	Margare	t Maddo	x	
Maryland	shou and M s mar		19a. Informant's Name/Relationship (Type, Print)		19b. Mailie	ng Address	s (Street a	ind Numbe	r or Rura	l Route Numbe	er, City or Town	n, State, Zip	Code)
Σ	is 1 and 2 of Health a item 27 is other trace		Connie E. Banks,	niece	-	-			ve Ro		Salis			
altimore,	ges 1 of Ho or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	CE	lace of Dispo emetery, crei	natory or o	other place	9)		ate	20c. Location	- City or To	own, State
Ë	t. Partmentent:		' 4 □ Donation 5 □ Other (Special		St.	Steph				-9- 0)5	Delma	r, De	•
Bal	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Mudical Examinat must be invitted at once.		21. Signature of Funeral Service Lice	nsee		S	hort	Fune	s of Facility ral H	lome				
			23a. Part1. Enter the disease, or com	plications that caused	the death	Do not ent	3 E. er the mod	Grov de of dying	e St. g, such as	De I	mar, De	e. 1994 rest,	0	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	е.	/	1 6	3 10	1	/.	fore			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequ	uence of):			/	- n	7012		7	<u> </u>
	Examiner		Sequentially list conditions,	b. Hy	12	end	en	in					4	2000
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	ı consequ	ience of):								
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9	tificat ng phy as th	ledi	In contract of the contract of											
Box	eath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of]Ectopic p	regnancy					ate of delive	ery Day Year
O.	ie dea the at hed fo	Physician/M	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of de	eath 5□	Other (s)	pecify)					iona i	ouy .ou
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f	Ph	Part II. Other significant conditions	contributing to death bu	t not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use con	ntribute to th	ne cause of death?
Vital Records,	uires tha signed	d by									101	/es 2 ⊡-1√o	3 ☐ Prob	ably 4 Unknown
000	w requires been si	Completed									24a. Was		. Were auto	psy findings available
Re	9 4 B	mo						-			autop perfo	rmed?	prior to cor death? 1 \(\text{Yes} \)	mpletion of cause of 2□ No
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of V	Physicien: r this certific ral director,	To	1 ☐ Yes 2 ☐ Mo			ER/Outpatier			4 (3774)		ne 5 Resid			y)
	ding P. After t	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	f M	28c. Injury Work	at :? Yes 2 ☐ N		28d. Describe h	now injury occu	rred	
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ò	after after Direct	Certification:	4 Homicide determined	building, etc	. (Specify	1)	001, 120101	,,			City or Tov			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			hysician: To the best of										
	the Hin 24 the Fu	edicai	one)	miner: On the basis of and manner sta		mon and/or in				in occurr				
	To To	Σ	29b. Signature and title of certifier				29	c. License	number	7	(-0	29d. Date sign	ea (Month,	uay, Year)
	3		11011	has	and the	02a) (T	Deleth	v.	-/	7	4 1	1/	4/10	J
	Ca		30. Name and address of person who William H. Robins			vic Av		alish	ourv,	MD	2 804	060	9.50	
	Sta	ite	31. Date filed (Month, Day, Year)		r's Signal		bart		1.					
1	Regist	ar	JOE T	COOL TOWN	Wes	St. 1	TO W							

Catherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended items 8 & 18 per fh/Certificate of Death wichd/7-13-1955/218 15 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0305 08 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Date of Birth 14/24 9. Birthplace (Month, Day, Year) legional Medical Center Sal/: If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 4 Hrs Birthplace
 Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F 8-24-194 Director Usual Residence of Deceder the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 10h County 77 is marked other then "natural", or items 23e or 28e-f show treumetic event, it e Modical Examiner must be notified at 1 Yes 2 No Como OrceSTER Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 806 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) OdUCTION 18. Mother's Name (First, Middle, Maiden S 17. Father's Name (First, Middle, Last) Laura Corbin 1 Arence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) natio 2

- apartment of Health at Important: If item 27 Is 1 any Injury or other treun 20.00. , MD 21851 daughter 806 Polemoke Cita 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 □Removal from State Macedonia Nemonal Park 05 16 WESTOVER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 917 west ISABELLA St MD 21801 SALISBUM Smith Funeral Home nunds Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician prendomina s intervision disease or condition resulting in death) PARumoma /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Oisease or inherential terms of the cause of t Due to (or as a consequence of): Examiner signed by the attending physician and deelached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending after death. I Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funerel I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

Registrar

DHMH 17 Rev 1/2001

State

Peninsula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jr. Mus

Agistrar's Signature

Silvia

03

31. Date filed (Month

20

Salisbury

100 E.

Kegima

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 0 0 5 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last Year Physician ESWE11 1444 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner EINER GEOR LEORGES NEE If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Dey, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1□M 200 F Days Months Hours Yrs JULY 03, MARÝLAND 2005 Director N/A Usuel Residence of Decedent Peges 1 end 2 should be filled within 72 hours efter deeth with the Menylend nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or Items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County XX Yes 2 □ No Directo MARYLAND PRINCE GEORGES FORESTVILLE than "natural", or items 23e or 28e-f the Medical Examiner must be notified 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code UNITED STATES 3608 MONTE CARLO PLACE 20747 Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ※XNo
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: BLACK P 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 YRS. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be JAMES THOMPSON MICHELLE CARSWELL 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Item 27 I MICHELLE CARSWELL / MOTHER 3608 MONTE CARLO PL. FORESTVILLE, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 7/08/05 SUITLAND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician end s the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 2 HNO 1 ☐ Yes 2 ☐ No 1 TY95 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c 27. Menner of Death Injury at Work? 5 Pending investigation 1 Natural efter deeth. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۾ 4 Homicide within 24 hours of To the Funeral To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name end address of parson who completed cause of deeth (Item 23e) (Type, Print) P. DR. Cheresyms 3001

Registrar **DHMH 16 Rev 6/95**

State

LACARDO DOANTASCIM

31. Date filed (Month, Day, Year)

. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 Year **Physician** July Robert Lee 5:00pM Jr. Coleman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges | Honder 1 Year | Houser 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5,1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 415-72-3560 NYM 2□F Nashville. 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No VA Director Stafford Stafford or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 306 Crossridge Ct. 22554 United States 23a 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 'natural', or Itema 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural," or the any injury or other ammatic event, the Medical Examble once. 1 Dyes 2 No Vietnam If Yes, Give Year or Date 1962-1968 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Corrections Officer District Of Columbia year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lee Coleman Sr. Ruby Jenkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5213 East Capital St. SE Washington, DC 20019 Sandra Ε. Coleman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 Donation 5 ☐ Other (Specify) Howard Medical School 7/6/05 Washington, DC 21. Signature of Funeral Service Lice Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear fairure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock, or hear Immediate Cause (Final disease or condition resulting in death) Physician a Circulatory collapse /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit Pneumonia that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical Acute renal failure use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à acute respiratory failure, anoxic encephalopathy, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 20 to failure cardiac arrest 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital a within 24 hours at To the Funeral D 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number , MD D0060021 07/05/05 VI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tulika Gupta, M.D., Prince Georges Hospital Center 3001 Hospital Dr. Cheverly, MD 31. Date filed (Month, Day, Year)

JUL 0 8 2005 State 20785 Registrar

			For 1 - State Registrar	State of	Marylar	•	artmen rtificate			and M	lental Hy	giene Reg. No. 2	2005	24079
	Physici		Decedent's Name (First, Midd WAYNE	DANIELS		CLARK					2. Date of De. Month	Day	Year 005	3. Time of Death 2:03P M
	/Medic Examir		4a. Facility Name (If not institution FREDERICK MEMO	on, give street and num	ber)	ошпис		Town, or	Location of	of Death	COM	4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 218–38–1588	6. Sex 7 123.M 2□ F	. Age (In yrs.	last birthday) 1 Yrs.		1 Year Days		24 Hrs. Min.	8. Date of Bird (Month, Da Sept 30	h y. _{Year)} 1943	9. Birth Cou Brun	place (State or Foreign intry) SWick MD
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Fred	erick		ty, Town or Lo								10d. Inside City Limits 1 ▼ Yes 2 □ No
	3a or 28a-	I Director	10e. Street and Number 3663B Peters	ville Road			10f. Zip	Code 21758	8			17	n of What Cou	intry?
036	172 hours after death with the Maryland "netural", or Itams 23a or 28a-f show citical Exercities must be notified at	by Funeral	11. Marital Status 1 Never Married 2 🔀 Mar 3 Widowed 4 Divorced	If Vac Give	es? 2 □ No		Was Deced If Yes, spec	ify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Ameri Black, White pecify: W.	
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	nd 2 s lith ar 27 is r trau		19a. Informant's Name/Relations Dorothy Clar			3663	BB Pet	ersv		Roa		xvill	e, MD	21716
Baltimore,	refit		20a. Method of Disposition 1 SkBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		late - C	Place of Dispo cemetery, crea sthave Garde	natory or or n Mem	ther place	-1	7/9/	05		tion - City or T erick,	
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	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that can to only one cause on ear a. Due to (o	r as a consequence	th. Do not ent	Pul	of dying	such as	cardiac o	r respiratory ar	rest,	ر -	Onset and Death
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O. Box 68	death certifica e attending pl ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3	∃Ectopic pre] Other (spe					230	Date of deliv Month	ery Day Year
ords, P.	w requires that the been signed by th should be detache	by	Part II. Other significant condition	ions contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to			he cause of death? bably 4 Dunknown
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Division		Certification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace C	f Injury - At he g, etc. (Specif	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		lumber of Rura	al Route Number,
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)	To the within 2 To tha complet	M	29b. Signature and title certified Robert 9	1. Luc	ng At	teno. ntho./ unger		License 2		2			igned (Month,	
9	AVVA			isHen, M.D	. 5	2 T.	T. D	ععند		FRE	DERIG	K, M	d, 2	1702
	Sta Registr		31. Date filed (Month, Day, Year	1 1 2005	gistra s Signa	ature K	Ann							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 2005 July John H. Conley Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ceci1 8 Rene Carr St. Elkton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 12 M 2□ F 1930 24 218-28-4496 74 November DE Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show or Items 23a or 28e-f show there must be notified at 1 ☐ Yes 2X No Directo MD Cecil **Elkton** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 Rene Carr St. 21921 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 GYes 2 ☐ No If Yes, Give 1948 1952 Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", o þ 3 Widowed 4 Divorced Year or Dates: er then "natur, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ilth and Mental Hygiene. 27 is marked other then 'r treumetic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen Proving 12 Safety Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Conley ဥ Dolly L. King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Irene M. Conley/Wife 8 Rene Carr St., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Importent: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake City *4 □ Donation 5 □ Other (Specify)

21. Sonature of Burloal Selvice Licensee July 12,2005 Bethel Cemetery Maryland 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as Cardac of respiratory arrest. MD shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Physician Concer 3 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) o detached 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Dey, Year) 29b. Signature and tyle of certifier 29c. License number 0 July 8, 2005 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cherapeake Hospice, ElkTon Registrar

			For		faryland / Dep			lental Hy	giene	
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	Funeral Director		5. Social Security Number 2	5. Sex 7. A 152 M 2 ☐ F	ige (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	v, Year) C	thplace (State or Foreign ountry) MD
			Usual Residence of Decedent					Nov 2	0 1926 +	
	arylan show	_	10a. State 10b. County	1.7	10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	he Ma	Director	MD Carro	L-L	Westmir	10f. Zip Code			10g. Citizen of What C	
	with with	i Dir	2930 Bird View	Poad			1157			outiny:
	death	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	USA 14. Race - Am Black, Whi	
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ehow diest Examiner must be modified at	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 ☐ If Yes, Give	No	1 ☐ Yes 2 1 € No	Specify:	r noarr, otc./	200	vhite
21215-0036	"natural",		3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Business	
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	filed withi Hygiene. Ather than	Com	11			Self Empl				Contractor
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Tyles	d 2 should be the and Menta 7 is marked traumatic even	2	Harvey M. Carr 19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Street a	Sarah P		r, City or Town, State,	Zip Code)
	ith a		Wm. Randolph Car	r/son	1100	JimDot D	rive We	stminste	er, MD 211	.57
Baltimore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1 XBurial 2 Cremation	B Removal from Stat	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	9) 7/13	^{Date} /2005	20c. Location - City or	Town, State
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Ba	permit. Pa Departmen Important: any injury		21. Signature of meral Service N	4	P		eral Home		apel, P.A.	21157
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	urs urs eral	edical Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis and manner s	t of my knowledge, death of examination and/or in	n occurred at the tim vestigation, in my op	e, date and place, sinion, death occurr	and due to the c red at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier	1 . /		29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
)	WIL		John W.	mold	With my	72	5443		7/11/200	35
	φ		30. Name and address of person w	d Nuton	death (Item 23a) (Type,	ole Roa	ed,	Westm	inster 1	M D21157
•	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 1		trar's Signature	berle	- /		,	

Physi /Med Exam Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Item Warled Evar, and Irusal to retilise

Baltimore, Maryland 21215-0036

CEPHTS, TYENE

Physician /Medica Examine

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
CF (3)
Sta Registr

1. Decedent's Name (First, Middle, Last) Irene S. Cephas 4a. Facility Name (If not institution, give street and number) Doctors Hospital 5. Social Security Number 6. Sex 1 Month Doctors Hospital 7. Age (In yrs. last birthday) 1 Month Day 4b. City, Town, or Location of Death Prince George's Nonths Days Hours Min. Month, Day, Year) Oct. 7, 1935 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1 _ State	Otate of Marytan	-	tment of Health ificate of Deal			00-	. 01.00
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Tresharis Name (First, Middle, Last) Treme Payne	(Specify only highes	t grade completed)	(Give ki	nd of work done during n	nost of working	165	. Kind of Busine	ss/Industry
Ramsey Butler 19a. Informant's Name Relationship (Type, Prent) Trene S. Cephas - Self 1077 Largo Rd., #517, Upper Marthboro, MD 20774 20a. Method of Disposition 1 Studies Sold Prince of Disposition (Name of All Postson) Date December of The Page of Disposition (Name of All Postson) Date December of The Page of Disposition (Name of All Postson) The Page of Disposition (Name of Disposition) The Page of Disposition (Name of Disposition (Name of Disposition) The Page of Disposition (Name of Disposition) The Page of Disposition (Name of Disposition (Name of Disposition) The Page of Disposition (Name of Disposition (Name of Disposition) The Page of Disposition (Name of Disposition) The Page of Disposition (Name of D	12th							ernment
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20. Place of Disposition Date Dat	19a. Informant's Name/Relations	nìp (Type, Print)		·				
1 Separation of Coher (Specify) 1 Separation of Coher (Specify) 1 Separation of Figeral Service Licenses 2 Separation of Sepa	Irene S. Ceph		_				rlboro,	MD 20774
22. Name and Address of Facility Stewart Funeral Home 4001 Benning, Rd., N.E. Wash., DC 20019 23a. Part Enter the disease, or complications that coassed the death. Do not enter the mode of dying, such as cardiac or respiratory great, including including the death of the death. Do not enter the mode of dying, such as cardiac or respiratory great, or condition resulting in clearly one cause, on each line. Sequentially list conditions, if any, leading to immediate death of the past 12 months? Let PLT C Due to (or as a consequence of): PERMANE Cause (Disease of finity that inhibited events respiratory and the past 12 months? 1 Ves 2 No 3 Probably 4 Unknown Part II. Other stentificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Was case referred to medical Ves 2 No 3 Probably 4 Unknown Part III. Other stentificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an any participant conditions contributing to death but not resulting in the underlying cause given in Part I. 25b. Was case referred to medical Ves 2 No 3 Probably 4 Unknown Vest 2 No 3 Probably 4 Vest 2 No 3 Probably 4 Vest 2 No 3 Probably 4 Vest 2 No 4	1 😾 Burial 2 🗌 Cremation	3 □Removal from State	emetery, crema	itory or other place)			,	
23a Part Effect the disease, or complications that coaksed the death. Do not letter the mode of dying, such as cardiac or respiratory arrest, interval Between shock of pherial failure. List only one cause, one sections in resulting in death) Sequentially is conditions, socially is conditions, cause. Either Underlying Cause (Disease or Injury resulting in death) Last Deep (or as a consequence of): Sequentially is conditions, cause. Either Underlying Cause (Disease or Injury resulting in death) Last Deep (or as a consequence of): Sequentially is conditions, cause. Either Underlying Cause (Disease or Injury resulting in death) Last Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Sequentially is conditions, continuous of the cause of death? Deep (or as a consequence of): Deep (or as a consequ	_	A						
shock (of hear failure. List only one cause or each line. Interval Between Onset and	DohnT.	MI I			ng Rd.,	N.E. Wa		20019
23d. It yes, outcome of pregnancy in the past 12 months? 1	Cause (Disease or injury that initiated events	b. Septic Due to (or as a consequence c. RESp72	suence of):	hock y far it/we	lure			
25. Was case referred to medical examiner? 1 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 3 \ \text{Securitier} \\ 2 \ \text{Nonner of Death} \\ 3 \ \text{Natural Securitier} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 3 \ \text{Nonner of Death} \\ 1 \ \text{Natural Securitier} \\ 2 \ \text{Nonner of Death} \\ 4 \ \text{Nonner of Death} \\ 5 \ \text{Pending investigation} \\ 3 \ \text{Subjective} \\ 4 \ \text{Nonner of Death} \\ 5 \ \text{Pending investigation} \\ 6 \ \text{Could not be determined} \\ 6 \ \text{Could not be so of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.} 6 \ \text{Could not be could not be cause of death (ltem 23a) Tyce, Print)} \\ 6 \ \text{Nonner of death} \\ 6 \ \text{Could not Nonner of death} \\ 6 \ \text{Nonner of death} \\ 6 \ Nonner of death	IF FEMALE:	22a If year autooms of grants	7					
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25. Was case referred to medical examiner?	Part II. Other significant condition	ns contributing to death but not resu	ulting in the und	erlying cause given in Pa	art !.		_	
25. Was case referred to medical examiner? Yes 2 No	flyper	fens TOL				autopsy	24b. Were prior to death	?
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA 2 Manner of Death 1 Natural 2 Naccident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Certifier (Check only one) 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Describe				26. Pl	ace of Death (C			
1 Second Processing Action 1 Second Processing Action 2 Second Processing Action 3 Second Processing Action 4 Second Processing Action 5 Second Processing Action 6 Second Proce		Hospital: 1 ∏ Inpatient 2 □		3□ DOA Other: 4□				pecify)
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(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/05/2005 30. Name and a idress of gers in year completed auser of death (Item 23a) Prope, Print) 8118 Good Luck Rd., Lanham, MD 20706	determine determine	not be ined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	t, factory, office	28f.	Location (Street City or Town, St	and Number or late)	Rural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	(Check only 2 Medical	Examiner: On the basis of examinat	wledge, death o tion and/or inve	occurred at the time, date stigation, in my opinion, o	and place, and death occurred a	due to the cause at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	29b. Signature and title of certifier	0		29c. License number	8446	29d.	Date signed (Mg	nth, Day, Year)
· · · · · · · · · · · · · · · · · · ·	30. Name and andress of gers in	completed rause of death (Item	23a) Frype, Pr				/	2270 110

DHMH 17 Rev 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death

1 - For State Registrer

Physician /Medical

		9	Southern MA	ryland	Hospital	Cliv	HON		Prince	George's
Funer Direct			Social Security Number 6. Sex		(In yrs. last birthda 57 Yrs	Months Days			1948 Lu	Birthplace (State or Foreign Country)
death with the Maryland ms 23a or 28e-f show		ctor	10a. State 10b. County	eorgeis	10c. City, Town or Upper	Location Marl	poro	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1
ath with the 23a or 21		Funeral Directo	10e. Street and Number 6004 - Croom	Statio	nRoad	10f. Zip Code	772	10g	Citizen of What	Country?
after or Ite	L	þ	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Yeavor Dates:		3. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No		Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc.
within 72 hours ene. than "natural", the Wedical Exa		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. De	cedent's Usual Occu ive kind of work done b. DO NOT use retin	during most of wo	rking	b. Kind of Busine	,
and ZIZI3-U d be filed within 72 hc snlal Hygiene. ted other than "natu		Ве Соп	17. Father's Name (First, Middle, Last)	2(+)	Ting	Erprint	Specia 18. Mother's Na	me (First, Middle, Ma		Governmen
Raryl 2 shoul 1 and Me 18 mark 18 mark	F	0	Joseph Jame 19a. Informant's Name/Relationship (Ty) Vutiva Tolber		Wife 60	ailing Address (Stree	Mude t and Number of Ri	ural Route Number, C	Dity or Town, State	a, Zip Code) 20772
MOFE, N Pages 1 and nent of Health nt: If item 27 nry or other tr			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dis	position (Name of rematory or other pla	aca) T		c. Location - City	or Town, State
그 눈 만 글	OUCE.		14 Donation 5 Other (Specify) 21. Signature of Funeral Service License	° llo	Maryland	1 Velerans 22. Name and Addr 2500 - Alle	ess of Facility	riduland	Funeva Sochas L	Service Pil
Physicia	ın		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused e cause on each lin	the death. Do not		ing, such as cardia	c or respiratory arrest	, r	Approximate Interval Between Onset and Death
/Medica Examine	er		resulting in death) Sequentially list conditions,	Coro	a consequence of):	Arter		sease		
be executed ician and burial-transit		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):					
BOX 00/0U, eath certificate be executed attending physician and for use as the burial-transit		edical	L							
the death certy the attendin		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of o	delivery Day Year
rdS, F quires that an signed b uld be deta	3	٥	Part II. Other significant conditions con	tributing to death bu	it not resulting in the	underlying cause g	ven in Part I.			to the cause of death?
VICAL RECORDS, F.O. strien: The law requires that the de certificate has been signed by the rector, page 2 should be detached		Complete)				24a. Was an autopsy performe	24b. Were prior to death	autopsy findings available o completion of cause of
r VICAL ystclan: 1 is certifical director, p.	0	e Q	25. Was case referred to medical examiner?	ospital:	2.6			ath (Check only one)		
this aldi	F	0	1 ☐ Yes 2. No '' 27. Manner of Death	28a. Date of Injur	y 28b. Time	IGHT 3 DOA		lome 5 ☐ Residence		pecify)
IVISION OI VITA r Attending Physician: ter death, ter death, iractor: After this certific by the funeral director,		atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur	/ Wo	ork?]Yes 2∐No		,, 000000	
JUVISION OF THE HOSPITED OF A TRENDING PHONE After death. To the Funaral Director: After the completely filled in by the funeral		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc	."(Specify)	street, factory, office		City or Town, S	itate)	Rural Route Number,
To the Hosp within 24 hour To the Funal	1	Medical	one)	ician: To the best of er: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	a, and due to the caus arred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
No.		2	29b.) Signature and title of certifier	nnell	Min	29c. Licen	02965	54 290	Date signed (Mo	nth, Day, Year) - 05
CHE			30. Name and address of person who con	npleted cause of de	eath (Item 23a) (Type	e, Print)	W W	larlbore	MO	20774

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 8 2005

nysicia		Registrar 1. Decedent's Name (First, Middle, La	ast)		Tillicate Of	Death	2. Date of De	Reg. No. 2	105	21.081 3. Time of Death
Medic		Ruby S.	Davis				July	Day 2, 2	Year 2005	9:36 A ^M
xamin	er	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	th	4c. County	of Death	
		Washington Advent 5. Social Security Number 6.5		yrs. last birthday)	Tokoma If Under 1 Year		8. Date of Bir	Montgo		oo /State or Foreign
neral ector			1□M 2 전 F 80	Yrs.	Months Days			y, Year)		ace (State or Foreig y) ington, I
iel	_	10a. State 10b. County MD Prince		City, Town or Lo					10	d. Inside City Limits
cutto	Funeral Director	10e. Street and Number	George's I	Hyattsvi	10f. Zip Code			40 072		1 ★Yes 2 No
1	=	4410 Oglethor	ne st Ant #	710	20781		·	10g. Citizen of \		
	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?			Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No	United 14. Rac	e - America	n Indian,
	þ	1 ☐ Never Married 2 ☐ Married ***Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 🛣 No		to Alcan, etc.)	Specify	ck, White, e	lack
14	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occu	pation during most of wo ed)	orking	16b. Kind of Bu	usiness/Indu	istry
	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			on Assis		D.C.	Publi	c Schools
	To Be C	17. Father's Name (First, Middle, Last Charles William				18. Mother's Na	me (First, Middle, Contee	Maiden Suman	10)	
other traumatic event, the Medical Examiner must be redified at		19a. Informant's Name/Relationship (Earl Stewart, II				tand Number or R				
133		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace)	Date	20c. Location -	City or Tow	n, State
		*4 □ Donation 5 □ Other (Special	fy) I			ete ry 7/			wood,	
any injury or o QDCB.		21. Signature of Funeral Service Lice	dsee	la constru		ess of Facility Fo		oln Fune entwood,		
ner	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con c. Ov ou Due to (or as a con d.	any of	Intery	Disea	. ce			
		IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Dat	e of delivery	
	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnanc Other (specify)	y .		Mol	ntn D	ay Year
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A STOURG DE GERACIEGO FOI USE AS TIE DU	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	of death 5	Other (specify)	,	1 🗆 1	rmed?	ribute to the 3 Probat Vere autops prior to compleath?	ay Year cause of death?
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il director, page 2 should be detached for use as the bu	To Be Completed by	23b. Was decedent pregnant in the past 12 gonths? 1	4 Pregnant at time 9 Unknown contributing to death but not Hospital: 1 Inpatient	of death 5	Other (specify) nderlying cause gr	ven in Part I. 26. Place of Decher: 4□ Nursing H	24a. Was autor period 1 yes ath (Check only of them)	an 24b. V ssy med? 2 3 No 1	ribute to the 3 Probab Vere autops prior to compleath? Pes 2	cause of death? oly 4 Unknown y findings available oletion of cause of
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			For State		State of	f Marylar		artment of H				00	21005
			Registrar 1. Decedent's Name	e (First Middle	l ast)			tineate or	Dealii		Reg. I	W-000	3. Time of Death
	Physicia /Medic		Wallace	Dobry						Ju	Ly 5	, 2005	11:00 A M
	Examin	er	4a. Facility Name (I			nber)		4b. City, Town, or				4c. County of Deat	
		•	Holy Cros			7. Age (In yrs.	last hirthday)	Silver S				Montgomer	hplace (State or Foreign
	Funeral Director		216-30-9		1⊠M 2□F	72	Yrs.	Months Days	Hours	Min. (M	ite of Birth Jonth, Day, Yes 21/1933	ar) Co 3 Mary	land
	put .		Usual Residence of 10a. State	Decedent 10b. County		10c Ci	ity, Town or Lo	ocation					10d. Inside City Limits
	faryla sho ed at	or	MD	Montgon	nerv		thersbe						1X Yes 2 No
	the N	rect	10e. Street and Nur			Juan	CHCLODE	10f. Zip Code			10g.	Citizen of What Co	untry?
	3a or	Funeral Director	348 North	h Summit	. Avenue.	Apt.2		20877				U.S.A.	,
	death	Jera	11. Marital Status		12. Was Dece	dent Ever in U	J.S. 13.	Was Decedent of H	lispanic Ori	igin? (Specify Y	es or No-	14. Race - Ame	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumetic event, the Madical Examinar must be notified at	by Fur	1 📉 Never Marri 3 🗌 Widowed	ied 2□ Marrie 4 □Divorced	Amed Fo 1 NYes If Yes, Giv Year or D	2 □ No e	.	n Yes, speciny Cuba 1 □ Yes 2 🗓 No	Specify:		etc.)	Specify: Wh	
Ö	72 hor	ted	(Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Occup	ation	t of working	16b.	Kind of Business/	ndustry
2	ithin 7	Completed	Elementary/Seco		College (1	-4or 5+)	life.	DO NOT use retired	d) ing mos	i or working			_
2	led w lygier her th		47 Fabrula Nama	/First # # # # # # # # # # # # # # # # # # #	4		Piano	Teacher	10 14-15-	ada Nama (Fina		elf-emplo	yed
Baltimore, Maryland 21215-0036	uld be filed Mental Hygi Irked other Itic event,	To Be	17. Father's Name	(First, Middi e , La	St)			unk.	18. Motne	er's Name <i>(First</i>	, Middle, Maid	len Sumame)	unk.
lan	2 should and Men is marke eumatic		19a. Informant's Na					ng Address (Street					
≥, ≤	and ealth m 27 ner tr		James J.		- Friend	lan.							, MD 20878
ore	ges 1 t of H if ite		20a. Method of Disp		☐Removal from			sition (Name of matory or other plac		Date		Location - City or	
ţ	then then tent:		* 4 □ Donation	5 Other (Spe	cify)	Ft.		ln Cremat					Maryland
Bal	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tonce.		21. Signature of Fu	1	1 ian L	Ver	10		ille :	Pike, R	ockvill		and 20852
			23a. Parti. Enter ti shock, or hea	he disease, or o	emplications that cally one cause on e	aused the dea	th. Do not ent	er the mode of dyin	g, such as	cardiac or respi	iratory arrest,		Approximate Interval Between
	Pnysician :	i u	Immediate Cause (disease or condition	(Final		hageal							Onset and Death
	/Medical Examiner		resulting in death)	1	Due to (or as a consec	quence of):						
5	Laminer	ē	Sequentially list con if any, leading to im-	nditions,	b. Due to (or as a consec	quence of):						
	uted 3 ansit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	erlying injury									
oʻ	cate be executed physician and the burial-transit	Exa	resulting in death) I	Last	Due to (or as a consec	quence of):						
68760,		dicai			d								
Box (death certific e attending p od for use as t	n/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, out			Dr				23d. Date of deli	very
	0 0 0	Physician/Me	in the past 12 1 ☐ Yes 2 [months? ☐ No		irth 2 ∐Feta ant at time of o own		⊒Ectopic pregnancy ☐ Other <i>(specify)</i>	· · · · · · · · · · · · · · · · · · ·			Month	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other signif		s contributing to de	eath but not res	sulting in the u	nderlying cause give	en in Part I	2:	3e Did tobacc	a use contribute to	the cause of death?
Vital Records,	The taw requires that the te has been signed by thoage 2 should be detached.	ed by									1 ☐ Yes		**
ecc	e taw re has be je 2 sho	Completed								24	ta. Was an autopsy	prior to c	copsy findings available ompletion of cause of
E E		Con								10	performed? ☐ Yes 2 🔼 l	? death? No 1 Yes	2 No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case refer examiner?		Hospital: . Y			oth Oth	or:	of Death (Chec			-
	Phys rthis ral dii	T.	1 ☐ Yes 2 📉 27. Manner of Deat		28a. Date		ER/Outpatier 28b. Time o	IL SEL DON	4 🗆 140		Residence escribe how in	6 ☐Other (Special Control of the Co	ify)
on	Attending Ph ir death. sctor: After th by the funeral	ation	1 XNatural 2 ☐ Accident	5 Pending investiga	(Mont	h, Day Year)	Injury	Wor	k? Yes 2 ∐!			,,	
Division of	i Dir	Certification;	3 Suicide 4 Homicide	6 🗌 Could no determin	ad 28e Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory, office			cation (Street ty or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled		29a. Certifier (Check only	1X Certifying	Physician: To the	best of my knows	owledge, deat	n occurred at the tin	ne, date an	d place, and du	e to the cause	(s) and manner as	stated.
	To the H within 24 To the Fi complete	ledical	one)		and manr	er stated.	ation and/or in			occurred at tr			
	Mith To	Σ	29b. Signature and	title of certifier	Dan.	Stor	()	29c. Licens				Date signed (Month	, ∪ay, Year)
1	140		ra	ven	44	ver	1	D0061	700		July	5, 2005	
-	ν,,	3	30. Name and addr Fabienne	J. Sant	e1 MD, 15	00 For	est Gle	en Road,	Silve	r Sprin	g, Mary	yland 209	10
	Sta Registr	-	31. Date filed (Mon	UL 08	2005 GO	egistrar's Sign	ature for	will					

		For State Registrar			ertificate of	Health and N Death	,	Reg. No	2000	261
Physici	an	Decedent's Name (First, Middle, Li					2. Date of D	Da		3."Time of t
/Medic		THOMAS 4a. Facility Name (If not institution, gi	ROOSEVELT	EDDY	4b City Town	or Location of Death	JUNE	29,	2005 County of Death	8:15
Examin	ier	4307 Crelin Pla			Lanham	or Location of Death			ince Geo:	
Funeral				n yrs. last birthday) If Under 1 Year		8. Date of E	irth		lace (State or ntry)
Director		579-36-8502 Usual Residence of Decedent	¹X ^{M 2□ F} 75	Yrs.	Months Days	Hours Min.	April	12,	1930Wash	ington,
Show	ō	10a. State 10b. County		0c. City, Town or L					1	0d. Inside City
28a-	Director	MD Prince G	eorge	Lanha	10f. Zip Code			10g. Cit	izen of What Cour	
30 or	Ö	4307 Crelin Plac	ee		20706				U.S.A.	,
ms 2	Jer	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Sp	Decify Yes or N		14. Race - Americ	
Department of Health and Mental Hygiene. Importent: if item 27 le marked other then "neturel; or Items 23e or 28a-f show eny injury or other treumatic event, the Medical Examture must be multilied at ange.	by Funeral	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	san, Mexican, Puerto Specify:	Hican, etc.)		Black, White,	etc. Lack
"netur	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of work	king	16b. K	ind of Business/In	dustry
then then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 3vrs	IITO.	Teacher	ia)		G	overnmen	t
Hygin Sther ant,		17. Father's Name (First, Middle, Las			reacher	18. Mother's Nam	ne (First, Midd	e, Maiden	Sumame)	
ked o	To Be	Webster	Eddy						,	
mar	-	19a. Informant's Name/Relationship		19b. Mail	ling Address (Street	and Number or Ru	h Seig€ ra! Route Num		r Town, State, Zip	Code)
alth a 27 le r tree		Vasquez A. Eddy	//Son			reek Rd.				
if Health item 27 other tr		20a. Method of Disposition			osition (Name of ematory or other pla		Date	-	cation - City or To	
nt:# ryor		1 ★Burial 2 Cremation 3 Comparison 3 Department of the Comparison 5 Department of the Comparison of t	Tranioval iloni State		l Veteran		/05	Chel	tenham,Ma	aryland
oorter inju		21. Signature of Funeral Service Light			22. Name and Addre				s Funera	
E E E			5		7474 Land	over Road				
Medical and physician and street transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of July that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):						
E S	dical		d							
attending for use a:	ician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of delive	ry Day Ye
attending for use a:	hysician/Medi	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐	Fetal death 3		у				•
gned by the attending be detached for use a:	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3[Other (specify)			tobacco u		Day Ye
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this certificate has been signed by the attending al director, page 2 should be detached for use a	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	1 Live birth 2 Land 4 Pregnant at time 9 Unknown contributing to death but not the Hospital: 1 Inpatient	☐ Fetal death 3 [lie of death 5 [lie of death	Other (specify) underlying cause gr	ven in Part I. 26. Place of Deal	24a. Wa auti per 1 Yes	tobacco u Yes 2 (s an oppsy formed? 2 No one)	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes	Day Ye e cause of dea ably 4 1 Unopsy findings available for au 2 1 No
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er death. rector: Afler this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	o Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not 1 3 Suicide 6 Could not 1 4 Homicide Homicide Could not 1 2 Accident German Could not 1 3 Suicide 6 Could not 1 4 Homicide Could not 1 5 Pending investigation 6 Could not 1 6 Could not 1 7 Could not 1 8 Could not 1 9 Could not 1 9 Could not 1 10 Could not 1 11 Could not 1 12 Could not 1 13 Could not 1 14 Could not 1 15 Could not 1 16 Could not 1 17 Could not 1 18	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye be) 28e. Place of Injury building, etc. (3)	□ Fetal death 3 [le of death 5 [le of death	Other (specify) underlying cause grained and 3 DOA Off 28c. Inju Wo M 1 treet, factory, office	ven in Part I. 26. Place of Deal ner: 4 □ Nursing Ho ry at rk? Yes 2 □ No	24a. Wa autroper 1 Ves th (Check only ome 5 Res 28d. Describe	tobacco u Yes 2 l s an ppsy formed? 2 No one) sidence (how injur (Street an, State)	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes 6 Other (Specify y occurred	Day Ye Day Ye Day Ye Day Ye Day Ye A Day Day A Day
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ther death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a.	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide determined 29a. Certifier (Check only 2 Medical Examined)	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (statement) thysician: To the best of mininer: On the basis of ex-	□ Fetal death 3 [le of death 5 [lot resulting in the understand of the understand	ont 3 DOA Off 28c. Inju Wo M 1 treet, factory, office	26. Place of Deal ner: 4 \(\sum \) Nursing Ho ry at rk? Yes 2 \(\sum \) No	24a. Wa autroper 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco u Yes 2 (s an ppsy ormed? 2 M No one) idence (how injur (Street an wwn, State, a cause(s)), date and	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes 6 Other (Specify y occurred	Day Ye le cause of decause of dec
4 hours after death. Anours after death. After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a.	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not 1 4 Homicide 1 Certifying P 29a. Certifier (Check only one) 1 Medical Examiner)	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (statement) thysician: To the best of mininer: On the basis of ex-	□ Fetal death 3 [le of death 5 [lot resulting in the understand of the understand	ont 3 DOA Office the occurred at the tinvestigation, in my of the occurred at the tinvestigation.	26. Place of Deal ner: 4 \(\sum \) Nursing Ho ry at rk? Yes 2 \(\sum \) No	24a. Wa autroper 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco u Yes 2 (s an ppsy formed? 2 No one) sidence (how injur (Street and own, State) a cause(s), date and	Month se contribute to th No 3 Prob 24b. Were autor prior to cordeath? 1 Yes 6 Other (Specify y occurred) d Number or Rura and manner as st place, and due to	Day Year) Pay Year)
4 hours after death. Anours after death. After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a.	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not 1 4 Homicide 1 Certifying P 29a. Certifier (Check only one) 1 Medical Examiner)	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye) 28e. Place of Injury building, etc. (3	□ Fetal death 3 [le of death 5 [le of death	underlying cause grant 3 DOA Office Injury Wo M 1 treet, factory, office th occurred at the tinvestigation, in my office #D00	26. Place of Deather: 4 Nursing Hory at rk? Yes 2 No	24a. Wa autroper 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco u Yes 2 (s an ppsy formed? 2 No one) sidence (how injur (Street and own, State) a cause(s), date and	Month se contribute to th No 3 Prob 24b. Were auto prior to cordeath? 1 Yes 6 Other (Specif) y occurred and manner as st place, and due to e signed (Month, I	Day Year) Pay Year)

State of Maryland / Department of Health and Mental Hygiene

10:35pm

9. Birthplace (State or Foreign

10d. Inside City Limits 1 Tyes 2 □No

Approximate Interval Between Onset and Death

Year

Day

1 ☐ Yes 2 ☐ No

Month

July 1, 2005

Panama

DHMH 17 Rev 1/2001

State Registrar 4. Corem

31. Date filed (Month, Day, Year) JUL 0 8 2005

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Meklit Workneh, M.D. 7227 Hanover Park Way Suite #A Greenbelt, MD 20770

D0062116

MD

. Jegistrar's Signature

The sales

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 10:55AM July **Physician** ANITA Rosemarie Flowers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center for Hospice Care Towson 8. Date of Birth (Month, Day, Year)
Jan. 13, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 ☐ M 2 💢 F 1941 Maryland 64 218-36-9352 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Show e 23a or 28a-f shover 1 ☐ Yes 2 ☑ No Randallstown Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21133 3807 Fernside Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. tiled within 72 hours after 1 Never Married 2 X Married Specify: White ŏ 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced natural ir than "natura Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pikeswood Park Rental Agent 12th othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of treumatic ever B Pages 1 and 2 should be Anita Henning Vernon Fred May ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu QNCS. 21133 Randallstown, MD 3807 Fernside Road Husband Kenneth R. Flowers 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State South Carroll Crematory July 8, 2005 Winfield, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 21. Sign ure f Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme sate Cause (Final discusse or condition resulting in death) 111.1462 CONCEIL Physician VICI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed use as the burial-transit the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown במנפ nas been signed by ו page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No certificate Physiclan: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Jo this tuneral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of eath Certification: After the Hospitel or Attending 5 Pending investigation Natural 2 Accident 1 🗌 Yes 2 🗌 No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 025205 (LLy) MZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. and Zizox - Shic 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

-4010ERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #2 1- State Registrar Per Phy,gc,7/14/05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Earline Year 6 Arland 1: YO AM 07 03 5-05 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hosni Southern Mary Innol Clinton Prince Georges 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Min. 1 ☐ M 2 💢 F Months Days Hours Director 83 579-34-6879 Jan.11,1922 Blackville, S.C. Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location in then "naturel", or Itams 23a or 28e-f show 10d. Inside City Limits Director 1 Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. ont: If Item 27 is marked other then "naturel", or Itams 23a or 2 Funeral 2128 13th Street, S.E. 20020 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Specify: Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Private other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ester Dowling ပ Jessie Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10005 Gray Stone Drive Upper Marlboro, Md. 20772 Judy Garland-Smith/daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Quantico Nat'l Cemetery 6/8/05 Triangle, Virginia 22. Name and Address of Facility Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licensee May E. Helgman MO 1374 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respondence. List only one cause on each line. Wash.,DC 20001 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respirater. yndroine Physician 7 days /Medical Due to (or as a consequence of): **Examiner** Schsis 13 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit certificate be executed extorateo 1/15001 13 dry the attending physician a hed for use as the burial. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown n signed by th. 1 be de** Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Certification: 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide

 $|0\rangle \neq |2\rangle |0\rangle$ ivision of Vital Records, P.O. Box 68760,

death. Director: within 24 hours after To the Funerel Direct

State

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Medical

45: CIAn

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c License number

7503 Surratts Rd Clinton Ho

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

07-03-05 D0029896

CARLOS ChiribogA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 7 2005

2. Registrar's Signature

Registrar

			1 - For State Registrar		partment of Health and ertificate of Death	Re	9. NO 115	21.090
	Physici	an	Decedent's Name (First, Middle, La SHELYA GOFMAN			2. Date of Death Month	Day Yeer	G. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	July th	03 2005 4c. County of Deat	
	ZAGIIII		Suburban Hospit	al	Bethesda		Montgom	ery
	Funeral Director		5. Social Security Number 288.94.2307 Usual Residence of Decedent	7. Age (In yrs. last birthda I M 2頃F 83 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		γ _{θαr)} 9. Birti Co , 1921 Ru	hplace (State or Foreign buntry) SSia
	yland Now		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	e Mar	ctor	Maryland Montgo	mery Rockvi	.11e			1⊠Yes 2□No
	or 28	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	ountry?
	s 23e	eral	95 Dawson Avenue		20850	Epocify Voc or No	U.S.A.	rion Indian
(O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f ehow any jury or other traumatic event, the Modified Enacting Enacting to Double and Apple.	Completed by Funeral	1 X Never Married 2 Married	1 ☐ Yes 2 🔀 No	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White	e, etc.
ğ	irel', o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	11te
21215-0036	n 72 h	lete	15. Decedent's E (Specify only highest gr	ducation 16a. Dec	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	orking 1	6b. Kind of Business/	Industry
72	within iene. Then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Social Worker		Social W	Vork
	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last	, 10010		me (First, Middle, M	aiden Sumame)	
ylar	Menta Merita arked	ToE	Israel Gofman			Boxer		
Maryland	2 short and and last market		19a. Informant's Name/Relationship (illing Address (Street and Number or R			
e,	s 1 and 2 of Health a item 27 Is other trav		Nana Lebanidze/I	20b. Place of Dis	Dawson Avenue, Apt		ckville, M. Oc. Location - City or	
μOμ	ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specia	Hemoval from State	Gardens 07/0		Rockville,	
Baltimore,	mit. P		21. Signature of Funeral Service Lice		22 Name and Address of Facility HINES—RINALDI FUNI			maryland
ď	Depar Impor		Noman A.	Parcentre	HINES-KINALDI FUNI 11800 New Hampshii	ce Ave. Si	ING. 1ver Sprin	ng. MD 20904
ı			23a. Part1. Enter the disease, or com shock, or heart tailere. List only	plications that caused the death. Do not e	enter the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Fnysician.		Immediate Cause (Final disease or condition resulting in death)	Pneumonia				Onset and Death 1 Week
	/Medical Examiner		resulting in dealth)	Due to (or as a consequence of):	11 700001			Michigan Colonia
	AL NE	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Diffuse Large B-Co	ell Lympnoma			1 Year
	cuted nd ransit	Examiner	that initiated events	c. Congestive Heart	Failure			1 Week
Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
8760,	physic physic the b	dica		_ d				
Box 6	death certificate be executed e attending physician and od for use as the burial-transit	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	B □Ectopic pregnancy		23d. Date of deli	,
Ö	that the dea ad by the att detached fo	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 🗗 No 9 ☐ Unknown		Other (specify)		Month	Day Year
ds, P.	es be	by	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.		accoluse contribute to	the cause of death?
000	aw requir as been si 2 should	olete				24a. Was an	24b. Were au	topsy findings available
of Vital Records,	The ate h page	Completed				autopsy perform 1 Yes 2		completion of cause of
/ita	Physiclan: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?	11		ath (Check only one)	
of o	Phys this al dii	-T	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati		Home 5 Residen	nce 6 Other (Spec	cify)
on	ding After fune	tion	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury		200. Describe 1104	rangery occurred	
Division	or At fter c Direct in by	Certification;	3 Suicide 6 Could not be determined	6 29a Place of Injury At home form	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Great only one) 1 X Certifying Pl	nysician: To the best of my knowledge, de namer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in thy opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and piace, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	-2010	29c. License number		d. Date signed (Month	
L			* Advagna	nMD	D0053615		July, 5th	h,2005
	i			completed cause of death (Item 23a) (Typ		#200 B-	level 1 1 a MT	20852
	Sta	to	Aruna Surendar 31. Date filed (Month, Day, Year)	Nathan, M.D., 11112	4	1/200, KOC	KATITE, MI	7 20072
	Registr	15	JUL 07	2005 Augus 15 16	parle			

TOD 7/3/05 del Stellya Cothnein

			1 - For State Registrar			artment of l		lental Hygier	ne 2005	24091
	Physic /Medi		1. Decedent's Name <i>(First, Middl</i> e, Las Katherine	() Louise	Greane	r		2. Date of Death Month July 4,	Day Year	3. Time of Death 3:45 P M
}	Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of De	
			Fox Chase Rehab.				Spring		Montg	omery
	Funeral Director		5. Social Security Number 6. Sec. 217-32-0890	X 7. Age □M 2X F	(In yrs. last birthday, 98 Yrs.	Months Days		8. Date of Birth (Month, Day, Yes March 2,	300=	irthplace (State or Foreign Country) aryland
	inyland ihow	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Ma 28a-f	Directo	Maryland Montgom	ery	Takoma P					ty∏Yes 2 No
	with sa or	Ö	7814 Garland Ave			10f. Zip Code		10g. 0	Citizen of What C	Country?
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ex	ver in U.S. 13.	20912 Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	USA nerican Indian.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in solitied at ance.	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)	If Yes, specify Cub 1 ☐ Yes 2 ☐XNo		Rican, etc.)	Black, Wh	ite, etc.
Maryland 21215-0036	72 ho "natur	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup	during most of worki	na 16b.	Kind of Busines:	s/Industry
121	within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) /ife.	DO NOT use retire omemaker	od)		0 17	
פָּ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)			Omemaker	18. Mother's Name	(First, Middle, Maid	Own Home en Sumame)	
Уa	ould b Ments arked	To	Joseph Novotny				Frances			
Mar	d 2 sh th and t7 Is m traum		19a. Informant's Name/Relationship (T. Kimberly D. Rigg					I Route Number, City		
	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			Park, M Location - City or	
<u>m</u>	Pages nent of Heart o		1 🔀 Burial 2 □ Cremation 3 □ I '4 □ Donation 5 □ Other (Specify,	lemoval from State	Arlington N	matory or other pla ational Cen	Ju_	ly 26	,	Virginia
Baltimore,	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	88	F:	Name and Address J.	ess of Facility.	Funeral H	ome Inc	ng, MD 20901
	Pnysician		23a. Part1. Enter the disease, or comp shock, otheart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line	death. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arrest,	ver spri	Approximate Interval Between Onset and Death 6 Months
8760,	Medical Examiner bhysician and the burial-transit	icai Examiner	resulting in death) Sequentially list conditions, any, leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): clerotic (consequence of): consequence of):	Cardiovas	gular Dis	case		6 Months
.O. Box 6	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
S,		by P	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require been sig should b	eted	Atrial Fibrillati	.on, stroke				1 Yes	2 No 3 P	robably 4 🔀 Unknown
Vital Record	The la ate has page 2	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 N	prior to death?	utopsy findings available completion of cause of 2 No
	Physician: Th this certificate ral director, pag) Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Death	,		
Division of	ling After fune	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Injur	AC Nursing Hor	ne 5 Residence 8d. Describe how inju		cify)
DIVISI	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (r - At home, farm, stre (Specify)			8f. Location (Street a City or Town, Stat	nd Number or Ru e)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of r ner: On the basis of ex and manner state	kamination andvor inv	occurred at the time restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as id place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. Da	ate signed (Mont)	h, Day, Year)
			Dass.			D	28656	J.	uly 5,	2005
			30. Name and ad erson who co			*				
	Sta	e.	Ravi Passi, M.D. 31. Date filed (Month, Day, Year)	32. Ranstrar's	ond Avenu	e, #404B,	, Silver S	pring, MD	20910	
	Registr	ar	31. Date filed (Month, Day, Year)	005	U B A	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005^{Year} Thomas W. Granzow July 5, 1:50A. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 8. Date of Birth (Month, Day, Year) DeC. 12, 1929 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **№** M 2□F 376-22-0537 75 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Maryland Chevy Chase 1 ☐ Yes 2 No 10f. Zip Code 20815 10g. Citizen of What Country? 10e. Street and Number 3126 Brooklawn Terrace United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. TYPs 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5±) Elementary/Secondary (0-12) Mental Health Developmental Psychologist 17. Father's Name (First, Middle, Last) Raymond Edward Granzow Mother's Name (First, Middle, Maiden Sumame) Elizabeth Capron Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Brooklawn Terrace Chevy Chase, Maryland 20815 Rita Schonberg -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 9/14/2005 Arlington, Virginia * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funese wice Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the decase, or complications that caused the death, shock, or head failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death KINSONS

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

3 Probably

Year

Month

Enysician /Medical

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y injury or oth

Impor any in page.

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

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Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "netural", or Items 23a or 28a-1 ehow try or other treametic event, Ite McGall Ex. nitrer mat be notified at any or other treametic event, Ite McGall Ex. nitrer mat be notified at

Baltimore, Maryland 21215-0036

Examiner

signed by the al

funeral

in by the

within 24 hours efter death To the Funeral Director: A

7:0

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Z No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Maither of Death Certification; 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physicien: of To the Hospitel

State

Medical

31. Date filed (Month, Day, Year) JUL 0 8 2005 Registrar

29a. Certifier

29b. Signature and tine of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

120

		For State	State of Ma	-	•			fental Hy		000	. ,	0000
		Registrar 1. Decedent's Name (First, Middle, Last)			Pertificat	e or L	veairi	2. Date of D	Reg. No	UUT	- 4	3. Time of Death
Physicia		EVERETT CHARLE	S GR	۸٧				Month JULY	7. Da	^y 2005	ear	
/Medica		4a. Facility Name (If not institution, give sti			4b. City,	Town, or	Location of Death	JOLI	7	. County of I	Death	6:38 PM M
ZAGIMIN		CIVISTA MEDICAL CE	ENTER		T.A	PLATA	. MARYLA	ND	(CHARLE	S	
Funeral		5. Social Security Number 6. Sex		(In yrs. last birtho	(ay) If Under	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9.	Birthpla	ace (State or Foreign
Director		117-26-0381 Usual Residence of Decedent	VI 20 F	69 Yrs	5.			NOV. 1	1,19	35 N	Counti EW Y	ORK
land ow		10a. State 10b. County	I	10c. City, Town o	r Location						10	d. Inside City Limits
ith the Marylar or 28a-f show	į	MD CHARLES		BRYANTO	WN							1 ☐ Yes 2 ☐ No
or 28s	Director	10e. Street and Number		Dittinito		Code			10g. Cit	tizen of Wha	t Counti	ry?
23a c	a	6991 LEONARDTOWN R	OAD		20	0617			U	. s.	Α.	
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or itams 23e or 28e-f show he Madical Examinar must be notified at	Funeral		2. Was Decedent E Armed Forces?		13. Was Dece If Yes, spe	dent of His cify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A	America Vhite, e	
36 is after	by F	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 🗆 Yes	2 (1) No	Specify:			Specify:		_
5-003 72 hours., annuar, annuar.	ed	15. Decedent's Educa	Year or Dates:]	16a. D	ecedent's Usu	al Occupat	tion		16b. K	ind of Busin	WHIT ess/Indu	
215 8. " " " " M. " " " "	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5-	- ti	live kind of wo fe. DO NOT u	ork done du se retired)	uring most of worki	ing				,
22 Page with the same of the same than the s	SO I		2		TO BROE	KER			AU	TOMOT	IVE	
ind 2 be filed tal Hygied d other	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name			,		
ryland hould be fill marked oth matic evant	၉	CLAUDE FRANCIS GRA	7 4 50 7				FLOREN			-		
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e, N 1 and 1 and Health Health ther tr	B	BARBARA V. GRAY /	WIFE	20b. Place of D			WN RD. BI	RYANTOW Date		ARYLAI		
imori Pages nent of fi		MXBurial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery,	crematory or o	other place						·
<u> </u>		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 	4 64	TRINITY			1			DORF,		HME.,P.A.
Bal Dermi		Youn Ba	T 265	M00641			NOTCH RI					
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Physician		Immediate Cause (Final disease or condition	Car	reer t	augn	1x a	nd he	tarka	ris	5 W	mo	Onset and Death
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	-	Sequentially list conditions, b.	Ovin to for se a	Sonsaguance of).								
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	led											
Box 6 Beath certification of a second of the second of th	Physician/Me	230. Was decedent program	c. If yes, outcome o		3 □Ectopic p	regnancy				23d. Date of		
e dea he att	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t		5 Other (sp					Month	U	ay Year
of Vital Records, P.O. Box 6 Physician: The law requires that the death certif rthis certificate has been signed by the attending ral director, page 2 should be detached for use as		9 ☐ Unknown Part II. Other significept spnditions contr	ibating to death but	not resulting in th	o undorhina c	nauca aine	n in Part I	23e Did	tobacco i	ico contribui	to to the	cause of death?
of Vital Records, F Physician: The law requires tha rthis certificate has been signed ral director, page 2 should be de	d b	Kenal	tailure	b	o underlying c	ause giver	TITT CITT.	1	Yes 2	_] Probat	
cord v requir	Completed	(Page Market	4440	VIII T	Marca	n		24a. Was				, 4
Rec he law he las l	d L	letro co	1 Com	7	200	0		auto	psy ormed?	deat	h?	by findings available pletion of cause of
f Vital Re	ပိ	25. Was case referred to medi	-tem-	1	lasse	PU	26. Place of Death	1 Yes	2×2 No	1 🗆	Yes 2	!□ No
ysicis s cert direct	n o	examiner?	spital: 1 Inpatien	t 2 ER/Outpa	itient 3 DC	Other				6 ∏Other (Specify)	
on of ding Phys	ü	27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury	The second secon	28d. Describe				
andir sath. or: Af	atic	2 Accident investigation	(М	1 🗆 Y						
Division or Attending after death. Diractor: After Jin by the tune	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	y - At home, farm (Specify)	, street, factor	y, office	1	28f. Location (City or To			r Rural f	Poute Number,
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Division or To the Hospital or Attending Pleath. To the Funaral Director: After the completely filled in by the funeral completely filled in the funeral completely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) Medicel Exemine	r: On the basis of a	examination and/o	eath occurred r investigation	at the time , in my opi	e, date and place, a nion, death occurre	and due to the ed at the time,	date and	and manne I place, and	r as stat due to ti	ed. he cause(s)
ro ths within ro ths comple	Z e	29b. Signature and title of certifier	.11/1-		29	c. License	number		29d. Dat	te signed (M	bnth, Da	ay, Year)
) d	11/		U D	- 469	79		7	181	0	5
	-	30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Ty			-			-		
10010:1		Sein, Collins P., MI	3460 01	d Washin	gton R	oad W	aldorf,	Marylar	nd 20	0602		
State		Sein, Collins P., M 31. Date filed (Month, Day, Year) JUL 1 1 20	32. Redistrar	's Signature	good							
Registra	r	JOE I I S	, , ,	37.5								

			1 - For State Registrar	State of Mar	yland /		nent of F			Reg. No		5	2419	L
В	Physici	an	Decedent's Name (First, Middle, La MAGGIE	ist)	CATI	LMAN			2. Date of De Month	Da		ar	3. Time of Deat	
j. 1	/Medic Examir		4a. Facility Name (If not institution, giv	re street and number)	GALI		City, Town, c	or Location of Dea	JULY	6 4c	. County of E	05 Death	6:15 A	F 141
1			PRINCE GEORGE'S	HOSPITAL			HEVERL				RINCE		RGE'S	
	, Funeral		Social Security Number 6. S	Sex 7. Age	(in yrs. last i	birthday) If L	Inder 1 Year		. (Month, Da	rth ay, Year)	9.	Birthpla	ice (State or Fore	əign
	Director		578-28-2778 Usual Residence of Decedent 10a. State 10b. County		92 10c. City. To	Yrs.			MARCH	24 1	.913 S	OUTH	CAROLI	NA
	Maryli 1 eho	ō	MD PRINCE O		SEA		ASANT						1 X Yes 2 □	
	r 28e	irec	10e. Street and Number				f. Zip Code			10g. Cit	izen of Wha	t Countr	y?	-
	23s c	raiD	6507 ADAK STREE	Γ			20743	3		U.S	S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23s or 28s-1 show supportant: if Item 27 is marked other then "naturel", or Items 23s or 28s-1 show shiply or other treumatic event, the Modical Exeminar must be notified at ADGS.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:	er in U.S.		ecedent of h specify Cubi es 2 X No	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))-	14. Race - A Black, V Specify: B	White, et	c.	
Ö	2 hou	ted	15. Decedent's E	ducation	16	Sa. Decedent's	Usual Occup	pation		16b. K	ind of Busin			
215	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind o life. DO No	of work done OT use retire	during most of wo d)	rking				,	
21	filed wi Hygien other th	Co	12th	1		HOUS	EWIFE				RIVATE	j		
Maryland 21215-0036	should be find Mental Harked of	To Be	17. Father's Name (First, Middle, Last ISAAC GLENN					SISLEY	me (First, Middle	, Maiden SWINI				
	and 2 sh ealth and m 27 le m		•	Type, Print) anddaughter	6	5507 AD	AK ST.	SEAT PI	EASANT,					
altimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐		ceme	of Disposition tery, crematory	or other plac		Date		ocation - City			
<u>=</u>	it. Pa		4 Donation 5 Other (Special 21. Signature of Funeral Service Licer		HARM	ONY CEM		7/1.			DOVER			
Ba	permit. Departri Imports eny Inju		by by	1~ /	1			OVER ROAI						
	Physician //Medical Examiner the private transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	consequence	e of):		ng, such as cardia	c or respiratory a	rrest,		1	Approximate Interval Between Onset and Death	
P.O. Box 68760	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	Fetal dea		oic pregnancy r (specify)	,			23d. Date of Month		y ay Year	-
	The taw requires thet the tee bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death but	not resulting	in the underly	ing cause giv	ren in Part I.			_		cause of death?	
Ö	been should	eted							10	Yes 21	XN0 3□	Probab	oly 4 ∐Unkno	wn
al Records,		Completed							24a. Was autop perfo 1 \(\text{Yes}	psy ormed?		to comp	y findings availa pletion of cause of No	
VItal	nysician: nis certifica I director, p	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital:	0 57 CD (0		Oth	or:	ath (Check only o					
ō	<u>_</u> = <u>_</u> a	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	28b	. Time of	28c. Injur Wor	4 Nursing r	fome 5 Resident			Specify)		
0	Attending Physician: r death. ector: After this certifics by the funeral director, i	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	rear)	Injury M		k? Yes 2 □ No						
Division of	1 th 6	Certification:	3 Suicide 6 Could not b		- At home, (Specify)	farm, street, fa	ctory, office		281. Location (: City or Tox			r Rural I	Route Number,	
	To the Hospitel or Attending I within 24 hours effer death. To the Funeret Director: After completely filled in by the funer	edical	one)	niner: On the best of example and manner state	xamination a	ge, death occu and/or investiga	rred at the tir ation, in my o	me, date and place	e, and due to the urred at the time,	cause(s) date and	and manne I place, and	r as stat due to ti	ed. ne cause(s)	
	To t To t	Σ	29b. Signature and title of certifier		•		29c. Licens				e signed (M			
1	3		on hylell	6 cen			15	3209			1-8	- a	5	
	3)		30. Name and address of person who DK WENDELL PIER	SON.	3001	Hospi	TAL.	DR	CHEVE	RLY,	MD	20	785	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	K)								

PHYSICIAN

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KNOWN HELFRICH,

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DHMH 17 Rev 1/2001

Registrar

JUL 1 1 2005

05-04556 John Hensley RJD

)	пспотсу		For State Registrar	State o	of Marylar		artment of rtificate of		d Mental Hy	/giene Reg. No.	2005	24096
N	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of D		Year	3. Time of Death 1815P. M
1	/Medic	al	John_	Steven	Hens	sley	# 63 T-	or Location of D				101)Р. м
1	Examin	er.	4a. Facility Name (If not institution Walston Switch	-		Rd	Salish		eath		County of Death	
	Funeral	· ·	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea	r If Under 24	Hrs. 8. Date of B	idh	9. Birth	place (State or Foreign
ė,	Director		310-88-9500	1 ⊠ M 2□F	31	Yrs.	Months Days	Hours N	9/15/1			ntry)
	pu *		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ច		omico		alisbur						1 ☑ Yes 2 ☐ No
	1 the 1	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	h with	a D	1002 Bell Ave.				21804	1		τ	JSA	
9	within 72 hours after death with the Maryland iene. Iene. rthen "naturel", or items 23a or 28e-f show the Mestical Examiner must be motilied at	Funeral	11. Marital Status 1 ☐ Never Married 2 ※ Marr	Armed Fo	2 📉 No		f Yes, specify Cu	ban, Mexican, P	? (Specify Yes or N tuerto Rican, etc.)		4. Race - Ameri Black, White	, etc.
21215-0036	ure!,	d by	3 Widowed 4 Divorced	If Yes, Gr Year or D			1 ☐ Yes 2X No	Specity:			Specify: V	hite
15-1	"nath	ete	15. Deceden (Specify only highe	it's Education st grade completed)		(Give	dent's Usual Doci kind of work don DO NOT use retir	e during most of	working	16b. Kir	nd of Business/Ir	ndustry
112	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Jockey	00)		Mus	sic	
p	Hyg Hyg Int,	0	17. Father's Name (First, Middle,					18. Mother's	Name (First, Middle	e, Maiden	Sumame)	
ılar	Mental Mental Parked c	To B	Steven E. Hens	sley				Maril	ynn Bur	ress		
Maryland	and and ie m	1 8	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stree	at and Number o	r Rural Route Numi	ber, City or	Town, State, Zi	p Code)
	1 and 1 Health tem 27		Jennifer R. Her	sley/wife		100	2 Bell A	ve., Sa	lisbury			
Baltimore,	iges 1 it of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation		State	cemetery, crer	sition (Name of natory or other pi	1	Date		cation - City or T	
Iţir	it. Pa intmer intent injury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Sa.		Cremate		/11/05	Sal	isbury,	MD
Ba	permit. Pages 1 Department of F Important: if its eny injury or ot		> Kall R	Lever	CFSP		O DITOM	TITTT VA	· Salisi	ury,	onal As MD 2180	sociation 4
8			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dear each line.	th. Do not ent	er the mode of dy	ing, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Mult		nyunes					Onsot and Death
	Examiner		3	Due to	(or as a consec	quence of):	•					
	4	e.	Sequentially list conditions, if any, leading to immediate	b. Dee to	(or as a consuc	учылев of):		<u> </u>				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S								
ó	e exection ar	EX	resulting in death) Last	Due to	(or as a consec	quence of):						
68760,	cate be executed physician and the burial-transit	dlcal		d					_			
		/Mec	IF FEMALE:	220 Hyan av	teems of ereco							
Вох	death certifii e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregn birth 2 Teta nant at time of c	aldeath 3	Ectopic pregnan Other (specify)	су		2	3d. Date of deliv Month	ery Day Year
o.	0 0 0	ysle	1	9□ Unkn		30400 32	Other (Specify)					
s, D	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
rds	w require been sig should b								1	Yes 2	No 3□Pro	bably 4 Unknown
eco	e law re has bed je 2 sho	ompleted							24a. Wa	s an opsy	24b. Were auto	opsy findings available ompletion of cause of
Œ	The ete h page	Com							per 1 💢 Yes	ormed?	death?	2 No
of Vital Record	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medica examiner?						Death Check only	one)		
of	Phys this al dir	ို	Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		ER/Outpatier	I SU DOA		ng Home 5 Res			
	ling After une	to to	1 □Natural 5 □ Pendir	ng (Mon	nth, Day Year)	28b. Time of Injury	W	uryat ork? ∐Yes 2.21No	Vehicle	now injury	d in mot	erator of
Division	i or Attending effer death. Director: After d in by the fune	flca	3 Suicide 6 Could	not be 28e. Place	e of Injury - At h	5.37 ome, farm, str	eet, factory, office		28f Location	(Street and	Number or Bur	al Route Number
ā	ei or s efte il Dire	Certification:	4 Homicide	build	ling, etc. (Speci	Street			Hemon	own, State)	walston s	witch Rd. Int.
	To the Hospitel or within 24 hours efter To the Funeral Directory to the Funeral Directory filled in the formula of the formul	Medical (29a. Certifier 1 Certifyir (Check only one)	ng Physicien: To the Examiner: On the b	pasis of examina	owledge, deat ation and/or in	n occurred at the vestigation, in my	time, date and p opinion, death o	lace, and due to the	cause(s) , date and	and manner as	tated
	o the o the omple	Mec	29b. Signature and title of certifie	and man	ner stated.			nse number			signed (Month,	
	- s - s		Dant Rus	the 10 men				OCI4E			7, 200	
	3		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type.	Print)					
725	_ 3			Southall, n		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	111	Penn Sti	reet Bal	timor	e, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year)		Restrar's Sign	ature	land.					
0.00	Registi	rar	00L I	± 2003	CHARLE.	13. 14	noul					

04507		For	State of Marylan				•	_	lible.
		1 - For State Registrar		Ce	rtificate of	Death		Reg. N2 ()	05 24097
Physic	an	1. Decedent's Name (First, Middle, L Shawn Bryant H					2. Date of De Month	Day	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Deat	July 4		3:08 a. M
Exami	101	Malcolm Grow			Camp S			Prir	ice George's
Funeral		5. Social Security Number 6. 57 9-11-07 52	Sex 7. Age (In yrs. 1 Mg 2 □ F	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Da	y, Year)	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	33				July 28	3, 19/1	Wash., DC
aryian show	-	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
the M	recto	MD Prince 10e. Street and Number	Georges For	restvi	10f. Zip Code			10g Citizen o	1 ☐ Yes ZXNo f What Country?
C 21215-0036 filed within 72 hours after death with the Maryland Hygiene. tither than "natural", or Items 23a or 28a-f show ont, the Medical Expris not must be excelled.	Funeral Director	1735 Forest Park	Drive		2074	÷7		U. S	
ems er m	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)	- 14. Ra	ace - American Indian, ack, White, etc.
rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ZÎNo If Yes, Give Year or Dates:	1	1☐ Yes 2ĂNo				^{ify:} Black
21215-UU36 d within 72 hours at giene. er then "natural; or the Medical Exert.	ted t	15. Decedent's I	Education	16a. Dece	dent's Usual Occup	pation	411-		Business/Industry
ithin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	during most of wo	rking	D 4 C	
filed w Hygier ther th		12 17. Father's Name (First, Middle, Las	st)	Truc	k Driver	18 Mother's Nar	ne (First, Middle,	Food S	
ed ala b	o Be	Sherman Hodges,					ley Long		arre)
0 0 0	-	19a. Informant's Name/Relationship							n, State, Zip Code)
the a		Shirley Hodges 20a. Method of Disposition					Date Date		n, DC 20032
Por pages and of the first filt.		1 💢 Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec			osition (Name of matory or other pla on Nation		-2005		and, MD
Battimore, permit. Pages 1 at Department of Hea important: if item any injury or othe		21. Signature of Funeral Service Lice	ensey		2. Name and Addre				me, P.A.
n 82558	L	Juan 19	ennsor			Branch A	ve., Ten	ple Hi	11s, MD 20748
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	mplications that caused the deat y one cause on each line. a	wou			c or respiratory a	rrest,	Approximate Interval Bestween Onset and Death
ped 11st	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or highry that initiated events	Due to (or as a conseq	uence of):					
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8760, ate be executed hysician and the burial-transit	cai		d						
.O. BOX 61 the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	□Ectopic pregnanc	у		1	late of delivery Month Day Year
IS, P	by Pt	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use co	ntribute to the cause of death?
ecords, law requires t as been signe							10'	Yes 2/CNo	3 ☐ Probably 4 ☐ Unknown
	Completed						24a. Was autop perfo		. Were autopsy findings available prior to completion of cause of death? Yes 2 No
r Vital ysician: ysician: is certifica director, p	o Be	25. Was case referred to medical examiner? Yes 2 No	Hospital: 1 ☐ Inpatient 2 📉	EB/Outpaties	nt 3 DOA Ott	100	ath <i>(Check only d</i> lome 5 🗌 Resid		ther (Specify)
ng Phy ter thi	h-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe I	how injury occu	urred
SIOF tendin leath. tor: Aff	catic	2 Accident investigati 3 Suicide 6 Could not	on July 4,2005	2123	A-M 1	Yes 2 XNo	-		shot
DIVISION Of VITA Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificial; filled in by the funeral director.	Certification:	4 Homicide determine		(y) t	- 4		City or Tov	Street and Nun vn, State) ((e whow	nber or Rural Route Number, Rd (amp Spring),
To the Hospital of within 24 hours a To the Funeral Completely filled is	edical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☑ Medical Exp	Physician: To the be t of my kno aminar: On the basis of examina and manner stated.	owle ge, deat ation and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the urred at the time,	cause(s) and n date and place	nanner as stated. n, and due to the cause(s)
To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and market Stated.		29c. Licens	se number		29d. Date sign	ed (Month, Day, Year)
10		tushal	Leeco MD		OCM	Œ		July	4, 2005
K [3]		30. Name and address of person who	1	п 23а) (Туре,		n Stroot	Bo1+	oro M	ownland 01001
- 61	ate	31. Date filed (Month, Day, Year)	2nberg M.D	ature	TIL Pen	m street	Daitim	ore, Ma	aryland 21201
Regist	ate	HH 6 7 20		. 1.					

			For State Registrer	State of I	Maryland		artment of I				giene	005	21.000
			Decedent's Name (First, Middle, I	ast)		-				2. Date of Dea	ath	000	3. Time of Death
	Physicia /Medic		ETHEL	ANNA H	IAHN					Month July	6 ,	2005	6:05 A M
	Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town,	or Location of	of Death		4c. C	ounty of Deat	h
			Frederick Memor				Frede					rederi	
П	Funeral			Sex 7. 1 ☐ M 2 🗗 F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	Month, Day	, Year)	Co	hplace (State or Foreign untry)
	Director		214-10-2389 Usual Residence of Decedent	1_	93				A	April 2	8, 19	12 Ma	ryland
	ytand Jow		10a. State 10b. County		1	Town or Lo							10d. Inside City Limits
	a-fst	ctor	Maryland Fre	derick	F	reder	ick						1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number		_		10f. Zip Code				10g. Citize	on of What Co	untry?
	ath w	ral		Road			217						States
	er de items	Funeral Director	11. Marital Status	12. Was Decede	s?	13.	Was Decedent of If Yes, specify Cul	Hispanic Ori ban, Mexicar	gin? (Speci 1, Puerto Ri	ify Yes or No- ican, etc.)	14	I. Race - Ame Black, White	
36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2, If Yes, Give Year or Date	os:		1 ☐ Yes 2 🔼 No	Specify:			s	Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-1 show the Madical Expirition in that be indiffied at	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation			16b. Kind	of Business/	
215	thin 7 e. an "n	Jple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done DO NOT use retire	a during mos ad)	t of working	7			
7	ed wi	Completed	6			Но	memaker					home	
ğu	be fill	Be	17. Father's Name (First, Middle, La							First, Middle,			
7	d Mer narke	2	David 19a. Informant's Name/Relationship		rdman	105 14-10		1	arrie		becca		
Ma	d 2 sl th and th and traur			ighter		9955	ng Address <i>(Str</i> ee Putman					ryland	
ē,	Heal Heal tem 2		20a. Method of Disposition	igneer	20b. Pla	ce of Dispo	sition (Name of		/ FIE			ation - City or	
ПO	ages ent of nt: If I		1 Burial 2 Cremation 3 14 Donation 5 Other (Spe		110	•	matory`or other pla Spires	, I	7 / 00 /	/2005	Exade	oriole N	Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than. Insturat, or items 23a or 28a-1 show any figury or other traumatic event, the Madical Exterings or unit to notified at ODGs.	1	21. Signature of Funeral Service Lic		Olus			ess of Facilit	y Star	uffer 1	Funar	al Hom	es, P.A.
ä	permi Depar Impo any Ir		Continone	Deles	en		621 Opos						
			23a. Part 1 Enter the disease, or co shook or heart failure. List on	implications that can	se the death.								Approximate Interval Between
	Physician	8 7	Immediate Cause (Final disease or condition	1	New	NOV	ua					1	Onset and Death
	/Medical Examiner		resulting in death)	Due to ur	as a con eque	nce of):	1	A	0	ac			117
	Lamines	-	Sequentially list conditions,	b	run	ras	cular	, n	Si	ar			Miers
	led Isit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or	as a conseque	nce ot):							Q
	axecur and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseque	nce of):							
8760,	cate be executed physician and the burial-transit	dical E		d									
9	tificat ig phy as th	led		- U									
Вох	eath certifi attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic pregnanc	cv			23	d. Date of del	,
	e deal	sick	in the past 12 months?		t at time of dea		Other (specify)					Month	Day Year
P.0	that the de	Phy	9 Unknown							an- Bida			
ds,	es on on	by	Part II. Dther significant conditions	contributing to dear	n but not result	ing in the u	nderlying cause g	IVen in Paπ I	•	236. Did to			the cause of death?
Ö	w requir been si should	etec											
Records,	e las has	Completed								24a. Was autop		prior to death?	topsy findings available completion of cause of
Vital			25. Was case referred to medical					00 BI		1 Yes	2 No	1 🗆 Yes	2□No
5	Physician: this certific ral director,	o Be	examiner?	Hospital:	atient 2 F	R/Outpatier	nt 3 DOA	ther		Check only o		□Other (Spec	cuful
10	g Physier this	n; T	27. Manner of Death	28a. Date of (Month,		8b. Time o	f 28c. Inju		and de trop	d. Describe h			ony)
jo	Attending r death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending investigat	ion	Day roary	mjary		Yes 2	No				
Division	or Atta	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	Injury - At hom, etc. (Specify)	ne, farm, str	reet, lactory, office)	28	31. Location (S City or Ton	Street and vn, State)	Number or Ru	ural Route Number,
Ω	oltal curs at urs at ural D								1				<u> </u>
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examination	edge, deat on and/or in	h occurred at the t vestigation, in my	time, date ar opinion, dea	nd place, an occurred	d due to the o d at the time, o	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licer	nse number			29d. Date	signed (Monti	h. Day, Year)
)	- > - 0		> Maks				T	126	516		JU	146	2005
			30. Name and address of person wi	o completed cause	of death (Item §	23a) (Type,	Print)	Λ		2 -			160
	3		MIEN J.GilS	6MM)	147	[MEY	ME	h	(4)	MD	211	42
	Sta Registr		31. Date filed (Month, Day, Year)	8 2005 N	i drar's Signatu	re ,	1						
	negioti	100			THE RESERVE	A.S.	A Contract !						

			•	For Stata Registrar		5	State o	of Mai		/ Depa	artment rtificate	t of H	ealth	and M	ental Hy	•	2005	260	199
		Dhusisi		1. Decedent's Name	First, Middle	e, Last)									2. Date of De	eath Da	ay Year	3. Time o	Death
	9	Physicia /Medic		Mavis	3		A1n	neda		ł	larris				July_	3	2005	3:45	P M
		Examin		4a. Facility Name (II				mber)			2.	, -	Location	of Death		40	c. County of Deal	h	
				Suburba								thes		Odlika			Montgo		
		uneral		5. Social Security N		6. Sex 1 □ N	/ 2⊠F	_		st birthday) Yrs.		Days	If Under Hours	Min.	8. Date of Bit (Month, Da	rth ay, Year	9. Birt	hplace (State untry)	or Foreign
		Director		052-24-38 Usual Residence of				8:	Δ						April		1923 Jam	aica	
	yland	MO TH		10a. State	10b. County				10c. City,	Town or Lo	cation							10d. Inside C	ity Limits
	Mar	B-f st	tor	DC					Was	hingt	on							1 <mark>x</mark> ∑Yes	2 🗆 No
	th the	or 28a-f show)ire	10e. Street and Nun							10f. Zip						itizen of What Co	untry?	
	death with the Maryland	238 ust b	Funeral Director	1836 Bur	ke Stre							0003					S.A.		
	ar de	tams	nne	11. Marital Status			. Was Dec	orces?		13.	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Or n, Mexica	igin? (Spe n, Puerto I	city Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit		
	36 rs afte	, or l	by F	1 Never Marri			1 □Yes If Yes, Gi Year or D	ve)		1 ☐ Yes 2	No Q	Specify.	:			Specify:	lack	
	-00-6	ature Cell E	ed		15. Decedent	t's Educat	tion			16a. Dece	dent's Usua	Occupa	ation			16b. l	Cind of Business/	Industry	
	215 7 rid 27	In "n	ple	(Spec	ify o <i>nly high</i> es	st grade o	College ()	(Give life.	kind of wor DO NOT us	k done d e retired	during mos ')	st of workii	ng				
	21.	giene ar the	Completed	12th			ooogo (, <u> </u>	S	eamtr	ess				P	rivate		
	Du e	d oth	Be	17. Father's Name (_									(First, Middle				
	Va outd	Men	၉	Crispin		lker								lia		rown			
	Maryland 21215-0036	7 is m traum		19a. Informant's Na Doyon C				er							Washi Washi		or Town, State, 2	(ip Code) 20003	
	e,	Department of Healing and Mental Hygelen insturel; or Itams 23e or 28e f show important: It item 27 is marked other than "naturel; or liter or other traumatic event, It e Modical Examinational and once.	1	20a. Method of Disp			0		20b. Plac	ce of Dispo	osition (Nam	ne of	Ţ		ate		ocation - City or	Town, State	
	Baltimore,	t: If it		1 ⊠Burial 2 [`4 □Donation	Cremation		noval from	State		-	matory`or ot	ther place	.	8/3/0	١٤		lington,		•
	# # F	artme ortan injur e.	f	21. Signature of Fu				_	Arı	ingto) II. 2. Name and	d Addres					ns Funer		
	B a	Impor eny ir			1 6			6									Marylan		
	7			23a. Part1. Enter the shock, or hear	ne disease, or	complica	cause on	eaused t	he death.	Do not en	ter the mode	e of dying	g, such as	cardiac o	r respiratory a	arrest,		Approxima Interval Be	te tween
	Pfi	ysician		Immediate Cause (disease or conditio	Final	,	0				M 130							Onset and	Death
		Medical		resulting in death)		(a.	Due to	(or as a	conseque	nce of):									, -
	EX	aminer		Sequentially list cor	nditions,	b		-		CONTRACTOR STATE	trom	BUS	517						
	pe	sit	Examiner	Sequentially list concause. Enter Unde Cause (Disease or that initiated events	madiata rlying	2	Due to	(ur on a	nons-qua	nearof)r									
10	60, be execut	and I-tran	хап	that initiated events resulting in death) (_ast	c.	Due to	(or as a	conseque	nce of):									
1	760, te be e	hysician and the burial-transit	cal E					,											
ĪŪ	x 687 certificate	g phy: as the	edlo			u.													
	Box auth cert	andin use a	M/u	IF FEMALE: 23b. Was decedent		23c	. If yes, ou		f pregnanc		□Ectopic pre						23d. Date of del	ivery	
10	. 8	/ the attending phr ched for use as th	Physician/Med	in the past 12 1 Tes 2	S No			nant at ti	me of dea		Other (spe						Month	Day	Year
0	P.O	igned by the be detached	hys	9 🗌 Unknown															
63	ords, P.O	been signed by should be detac	by	Part II. Other signif	icant condition					-	nderlying ca	ause give	en in Part	l.			use contribute to		
0	ecords,	been si should I	ted							10,0					100	Yes 2	!©aNo 3 □ Pr	obably 4 🗍	Unknown
0	11 >	hasb e 2 st	Completed	ATRI	AL F	-1131	21 66	ATI	ON						24a. Was	psy	24b. Were au prior to death?	topsy findings completion of c	available cause of
	B R	cate , pag													1 □ Yes	ormed? 2⊟₹N		2 X No	
2	of Vital R	certifi	Be	25. Was case reference examiner?			spital:					Othe			(Check only				
>	Of Phys	r this oral di	1: To	1 ☐ Yes 2 ☑ 27. Manner of Death			28a. Date (Mor			R/Outpatier 8b. Time o	nt 3 DO.	Bc. Injury Work			ne 5∐ Resi 28d. Describe		6 Other (Speciary occurred	city)	_
Mavis	/ision Attanding	th. : Afte s fune	tlor	1 ⊠ Natural 2 ☐ Accident	5 Pendin investio		(Mor	nth, Day	Year)	Injury	М		<br Yes 2□			,	,		
-	Division I or Attanding	r dea ector by the	ifica	3 🗀 Suicide	6 Could n		28e. Place	e of Injur	y - At hom	e, farm, st	reet, factory	, office		2			nd Number or Ru	ral Route Nun	nber,
5	io ë	s afte	Certification;	4 🗌 Homicide			Dulla	ling, etc.	(Specify)						City or To	wn, Stat	θ)		
Harris	The Hospitel	within 24 hours after death. To the Funarel Director: After this certificate has completely filted in by the funeral director, page 2.	Medical	29a. Certifier (Check only one)	12 Certifyin 2 Medical	g Physic Examine	ian: To the ir: On the b and mar	pasis of e	examinatio	edge, deat on and/or in	h occurred a vestigation,	at the tim in my op	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s date an	s) and manner as od place, and due	stated. to the cause(s	s)
	Tot	To 1	Σ	29b. Signature and	title of certifier	r					1		number				ate signed (Monti	/	
	_				ru	5					1	150	406	<i>y</i>			7/4	105	
E	R	(4)			3,50	WES.	TE	OWG	NSTO	ON D	PILE,		Rou	(V) LL	E, MD	20	2857		
	· · · · · · · · · · · · · · · · · · ·	Sta Registr		31. Date filed (Mon	th, Day, Year)		be	Registrar	's Signatur	Son	A.								
I							0.0												

			State of Ma State of Ma State Registrar 1. Decedent's Name (First, Middle, Last)	ryland / Depa <i>Cel</i>	artment of H			leg. No.2) 5 - 24 J.A.A
	Physici /Medio	al	OLWEN G. H	ELFRICH	th City Town	Landing of Deet	JULY 6		10:30 A ^M
	Examir	er	4a. Fecility Name (If not institution, give street and number) Shady Grove Hospital		4b. City, Town, or Rocky		n		omery
	Funeral Director		5. Social Security Number 207-10-3157 6. Sex 1 M 2 M F 8	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Sept. 1		B. Birthplace (State or Foreign Country) Pennsylvania
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	ocation OCKVille	<u>.</u>			10d. Inside City Limits 1 Yes 2 No
	h with the	Funeral Director	10e. Street and Number 9701 - Veirs Dr.		10f. Zip Code 2 C	850		10g. Citizen of Wh	at Country?
036	hin 72 hours after death with the Maryland B. an "natural", or Items 23s or 28s-1 show Medical Exament must be motified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 Yes 2 Never Married 2 Married 2 Married 3 Midowed 4 Divorced	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin? (S In, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
9500-91212	within 72 ane. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo f)		16b. Kind of Busi	
Maryland 2	al Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) Robert W. Owens			18. Mother's Na		Maiden Sumame)	
	is 1 and 2 should by Health and Ment of Health and Ment item 27 is markac r other treumatic a	:	19a. Informant's Name/Relationship (Type, Print) Susan Snyder-Daughter	11108			d.,Belt	sville,	Md.20705
Baltimore,	permit. Pages 1 Department of He Importent: If Iter any injury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	20b. Place of Disponsion Cedar Hi	matory or other plac		/11/05	20c. Location - C Allento	
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Ligensee		2. Name and Address Hysong	. Co T	nc.	ach De	
	Physician		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Acut	the death. Do not ent e. Ce Myocar				asir., DC	Approximate Interval Between Onset and Death 24 Hrs
68/60,	Medical Examiner be executed by his physician and the prival-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of):					
O. Box 6	death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date Month	
1	The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but Leukemia	it not resulting in the u	inderlying cause giv	en in Part I.			ute to the cause of death?
of Vital Records,		Completed					24a. Was autop perfor 1 Yes	med? de:	ere autopsy findings available or to completion of cause of ath?] Yes 2 □ No
on of Vita	ding Physiclan: Th h. After this certificate funeral director, pag	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		f 28c. Injun Work	er: 4 🗌 Nursing I	1	ne) lence 6 Dother ow injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune	Certificat	3 C Suiside 6 Could not be	ry - At home, farm, str . (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitel or A within 24 hours after or To the Funeral Direct completely filled in by	Medicai C	29a. Certifier (Check only one) 1 X Certifying Physicien: To the best of and manner sta	examination and/or in	h occurred at the tin	ne, date and place pinion, death occi	e, and due to the ourred at the time, o	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the Ho within 24 I	Me	29b. Signature and title of aertifier		29c. Licens 0 5	e number 8681	:	29d. Date signed (7/6/0	(Month. Day, Year) 5
C	K(5)		30. Name and address of person who completed cause of de Jude Alexander- MD	Shady Gr		entist	Hospita	al,Rock	ville,Md.
	Sta Regist		31. Date filled (Month, Day, Year) 32. Registra	r's Signature	e				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 5 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** 10:20 pm July 03, 2005 FLORENCE /Medical HOOD 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's County Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, March 18, If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country)
 NY. 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex Funeral Months Days 1□M 2MF Hours 577-30-9103 85 Director Usual Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland nant of Haalth and Mental Hygiena. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at \mathbf{m} 1 XYes 2 No Washington Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 244 34th St. NE 20019 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black Be Completed by 3 □ Widowed X NDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th n and Mental Hygiena. College (1-4or 5+) private Seamtress 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruben Atkins Nannie Wigginton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health important: If item 27 is Brenda 244 34th St. NE Washington, DC 20018 Hood, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/11/05 Washington DC. Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 22. Name and Address of Facility 20011 Bianchi FS. 814 Upshur St. NW Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pnemonia 2 Days Examiner Due to (or as a consequence of): Physician/Medical Examiner Mutiple Cerebrovascular Accidents 20 years Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed has TIYES ZXING 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) ဥ 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Aftart Natural 5 Pending eral Director: A filled in by tha fu 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a

To the Funeral C

completely filled edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deat / 46 123e) (Type, Print) heverly, Mid Kevath

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Leland William Hadcox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04588 State of Maryland / Department of Health and Mental Hygiene RPD State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Hadcox Leland William July 0949 P 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Temple Hills Road @ Salima Street Clinton If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth April 20, Birthplace (State or Foreign New York Social Security Number 116–28–9507 7. Age (In yrs. last birthdav) **Funeral** Months Min. Hours 1**⊠**MM 2□ F 68 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County r itams 23a or 28a-f ehow dreft ust be notified at 1 ☐ Yes XX No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 USA 8601 Temple Hills Road #31 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Heath and Mental Hygiene.
ant: if item 27 is marked other than "natural", or itams 23 ary or other traumatic event, It a Modical Extra ribral is ust 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No 1957— If Yes, Give Year or Dates: 80 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Staff Assistant U.S. Treasury 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward J. Hadcox Inez Cora Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosemary Glick / Daughter 18009 105th Street Court East Romay Lake, Washington 96391 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit, Pages Department of I Importent: If it any injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 07/09/2005 Kalas Crematory Edgewater, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Juneral Service Licenses 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final injuries Multiple **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Die to for as a consequence of Examiner if any, loading to immedia cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclan Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. I the a 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Driver of motor vehicle that collide Hospitel or Attending I 24 hours after death, Funerel Director: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 X No 9:35 P 7-7-05 with another meter vehill 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Temple Hills Rd 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Road Sational street clinton within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ai, M. C July 8, 2005 **OCME**

State

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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111 Penn Street Baltimore Maryland 21201

STEP	HEN D.	H	NNANT Amend #1, 7-12-05, per FHDR, HCHD, all of Death	ene
	of the State To a	-3	1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
	Physici /Medic		Stephan O. Hinnant Stephen D. Hinnant JULY 9	2005 U9JU A
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ELLICOTT CITY	4c. County of Death HOWARD
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Months Days Hours Min. (Month, Day, Oct., 13,	Year) 1966 9. Birthplace (State or Foreign Country) 1966 VIYAINIA
	0		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	a-1 aho	tor	Mn Howard EllicottGtu	1 □Yes 2 Dano
7	with the	Dire	2021. (1)	og. Citizen of What Country?
,	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. If Itam 271s marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, it a Maralcal Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:	Spacify: White
5-0036	72 hou 'natura		(Specify only highest grade completed) (Give kind of work done during most of working	6b. Kind of Business/Industry
2121	within liene. r then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) General Manager	erauson Enterprises
pu	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mis	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, M	i
Maryland	should nd Mer marke umatic	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,	Tima N City or Town, State, Zip Code)
	ss 1 and 2 of Health a f itam 27 is r other trai		Elizabeth D. Hinnantwife 8334 Glenmar Rd. Ellicate	10c. L cation - City or Town, State
nore	ages 1 ant of H it: If ita y or otl		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) 20b. Place of Disposition (Name of cemetery, crematory of other place) 20b. Place of Disposition (Name of cemetery, crematory of other place) 20b. Place of Disposition (Name of cemetery, crematory of other place) 20b. Place of Disposition (Name of cemetery, crematory of other place)	tock leading - City or rown, State
3altimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name an Address of Facility + rry + w.	rekel F.H. Inc.
ш	205 2 3		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre	st, Approximate Interval Between
F	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Introduct Starting Wound resulting in death)	Interval Between Onset and Death
_	/Medical Examiner		Due to (or as a consequence of):	
		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
_5	be executed ician and burial-transi	Examiner	Cause (Disease or injury that initiated sevents c. resulting in death) Last Due to (or as a consequence of):	
87	ate hys		d	
Box 6	ath certific attending p for use as	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
Э. <u>В</u>	Attending Physicien: The law requires that the death certific rideath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as:	Physician/Medical	in the past 12 months? 1	Month Day Year
, P.O.	res that thigned by	by Phy		acco use contribute to the cause of death?
ords	w require been sig should b		1 T Ye	s 2) No 3 Probably 4 Unknown
Rec	The law ate has b page 2 sl	Completed	24a. Was ar apply a performance of the control of t	prior to completion of cause of death?
Division of Vital Records,	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	
of	ding Physi n. After this o funeral din	n: To	Hospital: 1 Inpatient 2 Inpatient 3 DOA Cther: 4 Nursing Home 5 Resider 27. Manner of Death 1 Natural 5 Pending (Month, Day ear) 28b. Time of Work? 28d. Describe how ear linjury 1 28c. Injury at Work?	
sion	itending feath. tor: Afte the fund	cation	2□Accident investigation 01905 9140 M 1□Yes 2 No Sufffer	situr self
á	after deat after deat Director: d in by the	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	eet and Number or Rural Route Number, State) & 33-1 Conword Road
0,	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	
N.	To the within 2 To the Complet	Med	29b. Signature and title of certifier 29c. License number 29c.	od. Date signed (Month, Day, Year)
5/5	3)_) M. J. OCME	JULY 10, 2005
ال	九二		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltim	ore, Maryland 21201
	St. Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registar's Signature JUL 1 1 2005	a

			For State	State of	f Maryland / Dep			, ,	000	
			Registrar		Ce	rtificate of	Death		19. Ng. ()	5 24 104
	Physici /Medic		1. Decedent's Name (First, Midd	le, Last)	SUHOL	50~		2. Date of Death		ear S. Time of Death
	Examir		4a. Facility Name (If not institution			4b. City, Town, o	or Location of Deat	h	4c. County of	Death
					AL HOSPITAL		ERLY			NCE GEORGES
	Funeral Director		5. Social Security Number 217–30–0886	6. Sex	7. Age (In yrs. last birthday 7 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)_	Birthplace (State or Foreign Country) MARYLAND
	and **		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation				10d. Inside City Limits
	d eho	ъ	MD. PRINC	E CEODCEC		CAPITOL	петенте			1 Ves 2 □ No
	28a-	Director	10e. Street and Number	E GEORGES		10f. Zip Code	UETGUID	10	ng. Citizen of Wha	at Country?
	h with	al D	9401 HICKOR	Y ST.		20	743		П. 9	5.A.
	deat	Funeral	11. Marital Status		edent Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-	14. Race -	American Indian,
336	be filad within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or Itams 23a or 28e-1 ehow event, the Medical Examine in until or modified at	by Fu	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorce	ried 1 ☐ Yes	² X No	1 ☐ Yes 2 No	Specify:	o man, otc.)	Specify:	WHITE
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21215-0036	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1	life.	DO NOT use retire	d)	rking		
	filad w Hygier sthar th		12 17. Father's Name (First, Middle,	(ant)		RECEPTI	1	me (First, Middle, M	U.F.C.	.W.
Maryland		To Be	HOWELL	CHESTER	JOHNSON		MA		,	ARTESTY
ary	s 1 and 2 should by Health and Menta Itam 27 la marked othar traumatic ex	-	19a. Informant's Name/Relations	ship (Type, Print)		ing Address (Street	1			
	1 and 2 Health a lam 27 I	1	GERALDINE W	HEATLEY/SI	STER 940	1 HICKORY	ST., CA	PITOL HEI	GHTS, MI	20743
ore	00= 5		20a. Method of Disposition 1 Warrial 2 Cremation	3 Removal from	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	сө)	Date 2	20c. Location - Cit	ty or Town, State
altimore,	Page and Control	1	*4 □Donation 5 □ Other (\$21. Signature of Funeral Service	Specify)	PARKLAW	N CEMETER			ROCKVILI	LE, MD.
Ba	parmit. Depsrit Import any Inj		21. Signature of Funeral Service	ambeur	M00091 C	2. Name and Addre HAMBERS F 801 CLEVE	UNERAL HOLL AND AVE	OME & CRE	MATORIUM ALE, MD.	1,P.A. 20737
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that c	aused the death. Do not en	iter the made of dyin	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PU	LMONAR	I HY	PER	TENS	102	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1 1 1 1	. (0.10	- @	
		<u>_</u>	Sequentially list conditions,	b. Due to (or as a consequence of):	_ C07	V C-	DIC		
	nsit	뒤	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< 500.0 €	or as a correspondence ory.					
Ć.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai		L d						
9		Medi	IC CCMAIC.	24 1/11/14/14	3-2					
Вох	eath cartific attending p	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		come of pregnancy irth 2 Detail death 3	☐Ectopic pregnancy	y		23d. Date o	
0.	The law requires that the death cartificate has been signad by the attending to has been signad by the attending sage 2 should be detached for use as	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregn 9□Unkno		Other (specify)			MORRI	Day Year
0	that	by Ph	Part II. Other significant conditi	ons contributing to de	eath but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
Records,	w requires been sign should be	ed b	Cone	DUE	17EART	FAIL	unt	1 ☐ Ye	s 200 3[Probably 4 Unknown
00	aw requ is been 2 shoul	Completed)					24a. Was an		re autopsy findings available
Ä	The lav	mo.						autopsy perform	ed? dea	r to completion of cause of th? Yes 2□ No
Vital	ician: T certificat rector, pa	Be (25. Was case referred to medica examiner?				26. Place of Dea	ath (Check only one		
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 No		npatient 2 ER/Outpatie		4 Nursing H	lome 5 Reside		(Specify)
nc On	ding P. After funera	lon	27. Manner of Death Natural 5 Pendi	19	of Injury 28b. Time of the Day Year) Injury	Wor		28d. Describe hor	w injury occurred	
Division	death ctor: y the	licat	3 Suicide 6 Could		of Injury - At home, farm, si		Yes 2 □ No	28f Location (Str	eet and Number (or Rural Route Number,
Ο̈́	ial or Attendii s after death. al Diractor: A ad in by the fu	Certification:	4 Homicide determ	buildi	ng, etc. (Specify)			City or Town,		,
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifyi	ng Physician: To the Examiner: On the ba and mana	best of my knowledge, dea asis of examination and/or in her stated.	th occurred at the tin	me, date and place opinion, death occu	, and due to the ca irred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
.	To the within To the comp	Me	29b. Signature and title of certifie	OF T		29c. Licens	number	(29	d. Date signed (/	Month, Day, Year)
7	13	L	30. Name and address of person	who completed caus	e of death (Item 23a) /Time	Print)	- 10	6)		
			MEHRDAD	M057	ANN N	(D) 7	707 C	coltun	81.	VA.
	Sta	ite	31. Date filed (Month, Day, Year			borle				
	Registr	ar	JUL 0	7 2005	gistrar's Signature	pour				

		4	1 - For State Registrar	State of Marylar		artment of H			iene	5 21.105
	Physici	an	Decedent's Name (First, Middle)					2. Date of Dea	th	3. Time of Death
	/Media	cal	AUSTIN 4a. Facility Name (If not institution,	JOHNSON	1	JR	r Location of Deat		2, 20	
	Examin	ier	Holy Cross				er Spri		,	tgomery
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	10,1920	Birtholace (State or Foreign Country) N. Carolina
	Director		241-30-1684 Usual Residence of Decedent	84	Yrs.			Oct.	10,1920	
	Marylar f show	ŗ	MD 10b. County MON	ITGOMERY 10c. Cit	ty, Town or Lo Silve	er Sprin	ıg			10d. Inside City Limits 1 AYes 2 □ No
	or 28a-)irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
	s 23a	rai	11602 LeBaro			2090			U.S.A	
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show fra Modical Exartiner rest the multiple at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1237es 2 No 194 If Yes, Give Year or Dates: 194	12-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2점 No	lispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)	Black,	American Indian, White, etc. Black
21215-0036	72 hours afte "natural", or i	eted	15. Decedent (Specify only highes	s Education	16a, Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of Busin	ess/Industry
121	within ene. than "	ompi	Elementary/Secondary (0-12) 4th	College (1-4or 5+)	1	<i>DO NOT</i> use <i>retired</i> Leaning			Pepc	0
1d 2	e filed Il Hygi other vent, I	ВеСс	17. Father's Name (First, Middle, L	ast)		leaning	18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
ylar	d 2 should be filed within th and Mental Hygiene. 7 is marked other than treumatic event, the Mental treumatic event.	ToE	Oscar John					atience		
Maryland	nd 2 sh alth and 27 is rr r treurr		19a. Informant's Name/Relationsh Mary McLeod		19b. Maili	ng Address <i>(Street a</i>)2 LaBar	on Red	d Silve:	r Sprin	g ,MD 20902
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours partment of health and Mental Hygiene. In portant: If item 27 is marked other than "natural; in injury or pher treumatic event, If a Musical Expense.		20a. Method of Disposition 1	3 □Removal from State	cemetery, crei	osition (Name of matory or other place		Date / 2005	20c. Location - Cit	y or Town, State arboro, NC
altin	artmer ortant injury		*4 □Donation 5 □ Other (Sp 21 Signature of Funeral Service L	1 /1	22	awn Cem 2. Name and Addres	ss of Facility S	nowden	Funeral	Home, PA
ñ	e e e e		real 1	2 frue 4		246 N. V	lashing	ton St	Rockvil	le,MD20850
	Physician		Immediate Cause (Final disease or condition	complications that caused the deat only one cause on each line. Respirto			ig, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec Chronic	uence of): Obst:	ructive	Pulmon	ary Dis	ease	
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Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	quence of):					
8760,	ate be hysicia the bur	icai	·	d						
Box 6	leath certifica attending phi I for use as th	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of	f delivery
o.	at the death by the atte tached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown		Dectopic pregnancy Other (specify)			Month	Day Year
ecords, P	w requires that been signed t should be det	by	Part II. Other significant conditio	ns contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.			te to the cause of death? □ Probably 4 ŽUnknown
\sim	has has	Completed						24a. Was a autops perforr	n 24b. Wer y prio ned? dea	e autopsy findings available r to completion of cause of th? Yes 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitali		04		ath (Check only on		
of	Phys this ral dii	.: To	1 Yes 2 Nanner of Death	Hospital: 1 Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		4 Nursing r	lome 5 Reside	ence 6 Other (Specify)
ion	Attending It death. sctor: After by the funer	atior	1 X Natural 5 ☐ Pending investig	ation	Injury		k? Yes 2 □No			
Division	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ome, farm, sti fy)	reet, factory, office		28f. Location (St City or Town		or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medicel E	Physician: To the best of my kno exeminer: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	a, and due to the carred at the time, d	ause(s) and manno ate and place, and	er as stated. due to the cause(s)
		Ž	29b. Signature and title of certifier	PID		29c. License		2	9d. Date signed (A	
•	ν		Clay 1	Segalor	1	D52	261		July 7	,2005
			30. Name and address of person was Mr. Alan F	who completed cause of death (lter R. Segal, MD 1	n 23a) (Type, L 500 F	orest G	len Rd	Silver	Spring	20910
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 8	2005 32 Registrar's Signa	ature God	uli)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 200 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** B. ENA JENKINS 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner RICHEY HOSPICE JOSEPH BALTIMORE. BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2 ■ F 82 219 18 0954 Director 6-6-Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 □ No Director WASHINGTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 690 NICHOLSON ST. 20011 usa Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after to nent of Health and Mental Hygiene. ont: If item 27 le marked other then "neturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced þ BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) RESTAURANT. Elementary/Secondary (0-12) COOK 12 YRS
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be - Unavail SADIE CHASE tugutus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH JOHNSON / DAU. 1004 SAND STONE CT. SALISBURY MD 21804
20a Method of Disposition

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-8-2005 BRENTWOOD MD FT. LINCOLN 22. Name and Address of acility NES FUNCEAR HOME 21. Strature of Juneral Service Cicensee 23a. Bart1. Enter the disease, or complications that caused the death. Do not e thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LANCER Physician 4/2002 LOLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 2 Other (Specify) 1 ☐ Yes 211 No Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, fly! DOD2290 WIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAYES MICHAEL 838 N. UTAH ST. BALTIMORE

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

0 8 2005

JUL

		•	For State Registrar	State of Maryland	•		nt of H <i>te of E</i>		d Mental Hy	-	2005	21.10-
	Physicia /Medic		Decedent's Name (First, Middle, Last) Brenda N.	Jones					2. Date of D Month July		Year	3. Time of Deals 10:12 P M
1	Examin		4a. Facility Name (If not institution, give s Southern Marylan	_			, Town, or inton	Location of De	ath		ounty of Death rince G	eorge
	Funeral Director		5. Social Security Number 6. Sex 578-78-5319	7. Age (In yrs. la	st birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 H Hours M	lin. 8. Date of Bi (Month, D Sept.	rth ay, Year) 19, 19	9. Birthe Cour Vash	place (State or Foreign otry) ington, DC.
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		Town or Lor inton	cation					1	0d. Inside City Limits 1X Yes 2 □ No
	with the 3a or 28s	i Directo	10e. Street and Number 6807 Killarney S	treet		10f. Z	ip Code	20735		_	en of What Cour d State	•
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be motified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ⊡ Yes 2 ⊠ No If Yes, Give Year or Dates:			edent of Hisecify Cubas	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.)		Black, White, pecify: B1	
21215-0036	within 72 hor iene. r than "naturi	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	kind of v OO NOT	ual Occupa rork done d use retired,	uring most of	working	100	of Business/In	dustry
D	should be filed within the Mental Hygiene. marked other than imalic event, the Mental Count, the Ment	To Be C	17. Father's Name (First, Middle, Last) Freeman Charles Ni	chols, Sr.					Name (First, Middle ie Harris		umame)	
	nd 2 suith ar 11th ar 27 is r frau		19a. Informant's Name/Relationship (Ty Robert Earl Jones/						Rural Route Numb		Town, State, Zip 10735	Code)
altimore,	Pages 1 and nent of Healt int: If Item 2 iry or other (20a. Method of Disposition 1 1 1 1 1 1 1 1 1 1	emoval from State	ace of Dispo metery, cren Olive	natory of	other place		Date y 7, 2005		ation - City or To	
Balti	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service License	en Molos	22	. Name	and Addres	s of Facility	Pope Fur 5538 Mar Forestv	neral lboro ille,	Homes Pike MD. 207	47
,	Physician /Medical Examiner	Examiner	23a. Part1 Ester the disease or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A	O CAR ence of):			FARCT		arrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certific		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3	Ectopic Other (pregnancy specify)			23	d. Date of delive	ery Day Year
	luires that the de n signed by the a ald be detached f	d by Physician/M	Part II. Other significant conditions con MULTIPLE SCER	-	lting in the ur	nderlying	cause give	en in Part I.				ne cause of death?
Division of Vital Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed						-	24a. Wa auto peri 1 🗆 Yes	s an opsy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	dospital:			Othe		Death (Check only			
ot	Phys this al dir	-To	1 ☐ Yes 2 ☑ No 27. Manner of Death		R/Outpatien 28b. Time of	t 3□ I		- 4 🗀 I4UISIII	g Home 5 ☐ Res 28d. Describe			y)
sion	tending Ph seath. tor: After th the funeral	Certification:	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury	M		res 2 □No				al Route Number,
N	itel or Al rel Direc illed in by		4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)				City or To	wn, State)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	ledical	(Check only 2 Madical Exami	sician: To the best of my knowner: On the basis of examinational manner stated.	viedge, death ion and/or inv	estigati	on, in my op	oinion, death o	ace, and due to the courred at the time	date and p	lace, and due to	the cause(s)
)	To	Σ	29b. Signature and title of certifier				D 40				signed (Month,	
R	-(5)		30. Name and address of person who co	mpleted cause of death (Item 7503 SURR	23a) (Type. 4-77-5 /	Print)), CL	INTON,	MARYLA	ub S	20731	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure							

			1 - For State Registrar	State of Ma	ryland	-	artment of F <i>rtificate of</i>		d Mental Hyg	iene 9. No.2 A A	5 21.100
9	Physici		Decedent's Name (First, Middle, Last	Cheste	er Ea	arl .	Johns		2. Date of Deat Month July 6	, 2005	9:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give 8222 Canning Te				4b. City, Town, o	r Location of De		4c. County of	
	uneral Director		220-42-3144	x 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin. 8. Date of Birth (Month, Day, Jan 20,	Year) 9	Birthplace (State or Foreign Country) Florida
the Maryland	28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge 10e. Street and Number	eorge's	10c. City,	Town or Lo		nbelt	1	0g. Citizen of Wh	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with	3a or		8222 Canning Te	rrace				0770	'		USA
ING 21215-0036 be filed within 72 hours after death with the Maryland	d other than "natural" or Itams 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Black,	American Indian, White, etc. White
1215-C within 72 h	ene. than "natu he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of i	working	16b. Kind of Busir	,
S filled	othar /ant,	Be Co	12th 17. Father's Name (First, Middle, Last)				Roofe		Name (First, Middle, M	Priv Maiden Sumame)	vate
		To B	Earl Johns						Elizabeth		
	27 is		19a. Informant's Name/Relationship (T) Lamar Lourcey (F)	ype, Print) Brother)		10834	Badger i		Ru <i>ral Route Number,</i> Gaithersbu	•	
Pages	5 E C		20a. Method of Disposition 1 □ ② □ Oremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cen	etery, crei	osition (Name of matory or other place oln Cemete	ery 7/1		rentwood	
permit.	Important: I any injury o		21. Signature on Funeral Service Licens	Latimor	ع				endon/Hale rive, Land		
/M Exa	/sician and ledical aminer transit the privial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	ne cause on each lin a Due to (or as a b Due to (or as a c Due to (or as a d	conseque	nce of):	cute Inffuse	myo c	cordial navy a	inforc	Approximate Interval Between Onset and Death Death Onset and D
.O. BOX by	by the attending platched for use as t	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 19 Unknown	2 🗌 Fetal de	ath 3	Ectopic pregnancy Other (specify)		AUE -	23d. Date o Month	
Ords, P	s been signed be should be deta	ed by Pr	Part II. Other significant conditions co Hype Telesh	ntributing to death bu	t not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did tob		ute to the cause of death?
I KeC	certificate has bee irector, page 2 sho	Completed	of Chronic	e alcoha	ab	use	Ponusy	mal	24a. Was ar autops perform 1 Yes 2	prio ned? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
Or VItal Physician: T	certifi	o Be	25. Was case referred to medical examiner?	Hospital:			oth	ori	eath (Check only one		
ON OI	this ald	ıtlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 28	VOutpatier Bb. Time of Injury	f 28c. Injury	/ at	Home 5 Reside 28d. Describe ho		(Specify)
UIVISION To the Hospital or Attending F within 24 hours after death	taral Diractor	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home (Specify)	ə, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number of State)	or Rural Route Number,
ha Hospi	ha Funar pletely fill	Medical	29a. Certifier 1 Check only one) 1 Medical Exami	sician: To the best o ner: On the basis of and manner stat	examinatior	odge, death and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
To I	Com	≥	29b. Signature and title of certifier	W Lin	tag	mo	29c. License	247c	20	7-07-	
R	2		30. Name and address of person who co	ompleted cause of de	ath (Item 2:	За) (Туре,	Print) RAV	MIDER	K. Re	15 TAG	Τ
- *		te	31. Date filed (Month, Day, Year)	2. Registra			Cac	neve	vey		<u>- </u>

			1 - For State Registrer	e of Maryland / Depa	artment of H				
	Physici		1. Decedent's Name (First, Middle, Last) EMMA M. KNOTTS				2. Date of Death Month		5 2 Time of Dealth 9
	/Medic Examin		4a. Facility Name (If not institution, give street and RUXTON HEALTH OF D		4b. City, Town, or DENT	Location of Death		4c. County of CARO	Death
	Funeral Director		5. Social Security Number 222-20-5864 6. Sex 1 M 2 3	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) PRIL 11	(ear) 935	Birthplace (State or Foreign Country) DELAWARE
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CAROLINE	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Wes 2 ☐ No
	h with the 23a or 28e st be roti	ai Director	10e. Street and Number 420 COLONIAL DRIVE	}	10f. Zip Code 2162	9	109	g. Citizen of Wha	•
920	within 72 hours after death with the Maryland ane. then "naturel", or Items 23a or 28e-f show is Madical Examinatinast ke notified at	by Funerai	1 Never Married 2 Married 1 Yes	es 21☑No	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 212 No	spanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	Black, \	American Indian, White, etc. WHITE
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired,	turing most of won	16	5b. Kind of Busin	•
/land 2		To Be Co	17. Father's Name (First, Middle, Last) FRANK ELI LARRI	MORE		18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	
Mary	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type, Print) TERRY L. HARE		ng Address <i>(Street a</i>			-	
timore,	Page nent o int: If iry or		20a. Method of Disposition 1 Burial 2 Mremation 3 Removal fr 4 Donation 5 Other (Specify)	20b. Place of Dispo	sition (Name of natory or other place SHORE		Date 20	oc. Location - Cit	
Balt	permit. Departn Imports eny inju	l i	21. Signatur of Funeral Service Licens	To S	ATSON-Y	DELAWA	RE 1997	3	NC.
	Pnysician /Medical	-	Soa Part of redistries, or complications the sock, or heart fail e. List only one vause of the distance of the condition resulting in 9 lith.	Myocardial	er the mode of dying		or respiratory arres	it,	Approximate Interval Between Onset and Death
	Examiner	100	Due	to (or as a consequence of): to (or as a consequence of):					one week
8760,	ate be executed hysician and the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of):					
O. Box 687	ath certificate uttending phy or use as the	Physician/Medical	in the past 12 months?		Ectopic pregnancy			23d. Date of Month	delivery Day Year
rds, P.	w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions contributing t	o death but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	_/	te to the cause of death? Probably 4 Unknown
Vital Records,	The ate h page	Completed	3 Denu	nhia			24a. Was an autopsy performe	prior	
Division of Vita	uttanding Physicien: Th death. ctor: After this certificate y the funeral director, pag	ation: To Be	th Check on one ome 5 TResidence 28d. Describe how		Specify)				
DIVIS	itel or Attendi us after death. rel Director: A lled in by the fu	Certification:	4 Homicide bu	ace of Injury - At home, farm, stre uilding, etc. <i>(Specify)</i>			City or Town,	State)	r Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, death e basis of examination and/or invanner stated.	occurred at the time restigation, in my op	inion, death occur	red at the time, date	se(s) and manne a and place, and . Date signed (M	due to the cause(s)
	2 2 3		R. R. Snort.			616 88		07/0-	7 /05
	Sa			MD 2108 DID	Print)	DRIVE	MESTE	R MO	1-21619
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			For	State of N	/laryland	_				and M	ental Hy	giene	e			
			1 - State Registrar	()		Cei	rtificate	of D	eath	1		Reg. No	200	5	24110	_
	Physici	an	Decedent's Name (First, Middle DONALD J. KAS								2. Date of De Month	Da	y 2	ear	3. Time of Death	4
	/Medic Examin		4a. Facility Name (If not institution		or)		4b. City, T	own, or l	Location o	of Death	July_	40	. County of	05 Death	5:15 A M	_
	LAGIIII		Shady Grove A	dventist Ho	spital		Roo	ckvi	11e			M	lontgo	mer	У	
ľ	Funeral		5. Social Security Number	6. Sex 7. / 1)X M 2 ☐ F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9	. Birthpi	lace (State or Foreigr	n
	Director		232–38–7685 Usual Residence of Decedent	-	75	115.					Sept.	11,1	929 W	est	Virginia	
	nyland show	_	10a. State 10b. County		10c. City,	Town or Lo	cation							11	0d. Inside City Limits	
	he Ma 8a-f s	Director	110.0	gomery	G	aithe	rsburg								1 ☐ Yes 2 📉 No	
	with the	Dir	10e. Street and Number 331 Wye Mill C	ourt			10f. Zip (879				izen of Wh		-	
	death	Funerai	11. Marital Status	12. Was Deceder		. 13. \	Was Decede			gin? (Spe	cify Yes or No Rican, etc.)		ed St	Americ	an Indian,	
9	after or Ite	/Fui	1 Never Married 2 Marr] No		it Yes, sp <i>eci</i> i 1 □ Yes 2		, Mexican Specify:	i, Puerto I	Rican, etc.)	ĺ		White,		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show for Modical Examiliar for set the nutified at	ed by	3X Widowed 4 ☐ Divorced	Year or Dates	: Korea	·	dent's Usual				·	105 1	Specify:	*****		_
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Maryland		ø	17. Father's Name (First, Middle, Joseph Kasun	Last)				'			(First, Middle					
3	should be and Mental I smarked or umatic eve	^L	19a. Informant's Name/Relations	nin (Type Print)		19b Mailir	na Address /	Street ar			Rocka			ate Zin	Codel	
Ma	nd 2 saith an 27 is r trau		Michael Kasun	(Son)							Air,			110, Др	Code	
altimore,	of Head		20a. Method of Disposition	a Daniel from Ste	20b. Pla		sition (Name		ı 1	D	ate		ocation - Ci	y or To	wn, State	i
Ĕ.	Page Intent	1	1 🎾 Burial 2 □ Cremation `4 □ Donation 5 □ Other (S)	pecify)		L Soul	S			July 2005			nantov		Md.	
Bai	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or gibar traumatic events.		21. Signature of Funeral Service	icensee							Vol Fur				1. 20877	
			23a. Part1. Enter the disease, or	complications that caus	ed the death.								sburg	-	Approximate Interval Between	
	Pnysician	8 10	shock, or heart failure. List	only one cause on each Cirrho	line.										Onset and Death	
	/Medical		disease or condition resulting in death)	a	is a conseque	ence of):								1	<i>l</i> ears	
B	Examiner	-	Sequentially list conditions,	b. Due to /or o		of								1		S.
_	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying	Dus to (b) a	is a conseque	ance or):										
oʻ	be executed sicien and burial-transit		that initiated events resulting in death) Last	c Due to (or a	is a conseque	ence of):					-					-
8760	ate hy	Ilcai		d												
9	eath certifica attending plant for use as t	/Mec	IF FEMALE:	23c. If yes, outcom	ne of pregnan	PM/									n land	7
Box	death a atten	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth	2 ☐ Fetal of at time of dea	leath 3 🗆	Ectopic pred					1	23d. Date o Month		y Day Year	Ĭ
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	res tha igned be det	by	Part II. Other significant condition Gastrointesting			ing in the ur	nderlying cau	use given	in Part I.				_		e cause of death?	1
ord	w require been sig should b	eted	Gastionicestin	ar breedin	క						-		1		ably 4 \understand	_
Vital Records,	r sician : The law s certificate has I director, page 2 s	Completed									24a. Was autor perfo		prio	r to coπ th?	sy findings available pletion of cause of	
ta		0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆	Yes	2 No	
<u> </u>	Physici this cer	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 👿 Inpa	tient 2 E	R/Outpatien	t 3 DOA				ne 5 Resid		6 Other (Specify)	
Division of	ding Pl h. After tl funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		jury 2 Jay Year) 2	8b. Time of Injury		c. Injury a Work?	at	2	8d. Describe					
ISIC	I or Attendi after death. Diractor: A	ertification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	niury - At hor	ne. farm. stre	M eet factory		es 2 □ N	-	8f. Location (Street an	d Number o	or Rural	Route Number,	-
2	spital or A ours after saral Dirac filled in by	Certi	4 Homicide determi	building,	etc. (Specify)			011100			City or Tov	vn, State)		, , ,	
	lospit hours unara	edicai (29a. Certifier 11 Certifyin (Check only 2 Medical I	g Physicien: To the bes exeminer: On the basis	of examination	edge, death	occurred at	t the time	, date and	d place, a	nd due to the	cause(s)	and manne	er as sta	ited.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medi	one) 29b. Signature and title of certifier	and manner	stated.			License r			o at the time,					_
				-				D586					e signed (A			
	15+1		30. Name and address of person	who completed cause of	death (Item 2	23a) (Type,							, , ,			-
			Dr. Jude Alex	ander M.D.	9901	Medi	cal Ce	nter	Dri	ve	Rockvil	lle,	Md.	2085	0	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32 Jegis	trar's Signatu	re do	edi									
	5 A 1	-		Program.												

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nemer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hunder 1 Year 1911 17 cm ·cal (e Hone 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year Min. 1 M 2 ☐ F 83 208-24-4391 Yrs. Director March21,1922 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If item 27 Is marked other than "neturel", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits items 23a or 28a-f shov Maryland Prince George's Bowie 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 12418 Sarah Lane 10f. Zip Code 10g. Citizen of What Country? 20715 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner to 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, College (1-4or 5+) Elementary/Secondary (8-12) Display Manager Lerner Shops traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heinrich J. Kahn Selma Gras Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley R. Kahn -son 1834 North Forest Ct., #D Crofton, Maryland 21114 oartment of Health oortant: If item 27 i lojury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 7/7/2005 Department of Important: If eny injury or Alexandria, Virginia ' 4 ☐ Donation 5 ☐ Other (Specify) Đồnaid V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequ Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Be Completed director, page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tyes 1 Impatient 2 ER/Outpatient 3∏ DOA this 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. 28d. Describe how injury occurred injury at Work? Injury atura 5 Pending 1 ☐ Yes 2 ☐ No cident investigation 24 hours after death Pruneral Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and profiner stated. Medical 29a. Certifier (Check only ons) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 6/05 D58922 ho completed cause of death (Item 23a) (Type, Print) 2001 hed, cal MD. Annapolis MD 21401 **⋒eg**istrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 8 2005 Registrar

			For State		State of Ma	arylar	•		nt of H I <i>te of L</i>		Mental Hy				
			Registrar 1. Decedent's Name (First, I	fiddle Lac	<i>t</i>)		CE	erunca	te or t	Jean	2. Date of D	Reg. No	C U U	5-	3 Time of Death?
п	Physicia		Sebert	iliddie, Lus	Wayne		Ke	iffer			July 7	, 2005	y Ye	ar	12:05 P M
	/Medic Examin		4a. Facility Name (If not insti	tution, give	street and number)				•	Location of Deat		40	. County of D		_
			Millennium Healt	hcare	of Forestvi	lle_			restvi				rince Ge		
	Funeral Director		5, Social Security Number 579–62–0876	6. Se		e (In yrs. 56	last birthday Yrs.	Month:	er 1 Year s Days	Hours Min.		irth (ay, Year) 1948	9. B	Birthpl Coun lash	lace (State or Foreign try) Lington, DC
-	pu .		Usual Residence of Deceder			10c. Ci	ty, Town or I	ocation						10	0d. Inside City Limits
	the Marylar 28a-f ehow netified at	5		ice Geo	roe's		istrict		ts						1 ☐ Yes 2x ☑ No
	r 28a-	rect	10e. Street and Number		280 0		1001 100		ip Code			10g. Cit	tizen of Wha	Coun	try?
	th with	a D	7420 Marlboro I	ike				20	747				USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23a or 28a-f ehow other traumatic event, the Medical Examinar mast be notified at	by Funeral Directo	11. Marital Status 1 ☑ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:		J.S. 13		edent of Hi becify Cuba 2\bar{2}\lambda No	ispanic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - A Black, V Specify:		etc.
5-0	72 ho	eted	15. Dec (Specify only i	edent's Ed			16a. Dec	edent's Us	ual Occupa	ation during most of wo	rking	16b. K	and of Busine	ess/Inc	lustry
121	within ne.	Completed	Elementary/Secondary (0	1	College (1-4or 5	i+)		ab Dri)			Livery		
	filed withi Hygiene. other than		12th 17. Father's Name (First, Mi	ddle, Last)						18. Mother's Na	me (First, Middl	e, Maider	Sumame)		
lan	should be find Mental H marked of umatic eve	To Be	Sebert Hector	Keiffe	r					Dai	rlene June	e Laws	son		
Maryland	2 shou and N Is mai		19a. Informant's Name/Rela	tionship (7	ype, Print)					and Number or R				e, Zip	Code)
Σ.	and seelth m 27		Keith A. Keiffe	er / Br	rother	20h I	_			e Forestv	ille, Mary	-	20747 ocation - City	or To	State
Baltimore,	permit. Pages 1 and 2 sh Depertment of Heelth and Important: If Item 27 Is n eny injury or other traum		20a. Method of Disposition 1 → Burial 2 □ Crema	tion 3 🗆	Removal from State	1	Place of Disp cemetery, cr			1					
Itin	nit. Pa artmer ortant injury	1	° 4 ☐Donation 5 ☐ Oth			Ceda	ar Hill	22. Name	and Addres	s of Facility	11, 2005				Control of the contro
Ba	Depermine Depermine Important in poores.		> /h /	101				6160	Oxon H	fill Road (orge P 1	Kalas Mary	Funeral land	2072	P.A.
			23a. Per . Enter the disease shock, or heart failure.	e, of comp List only	olications that ceused one cause on each li	the dee	th. Do not e	nter the m	ode of dyin	g, such as cardia	c or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician	8	Immediate Cause (Final disease or condition resulting in death)	_	a. CANCER (ITH N	1ETAS:	rasis					
1	/Medical Examiner		resulting in doubly		Due to (or as			TIMOD							
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	J	b. PITUITA! Due to (or as			OPION						+	-
	cuted nd ransit	Examin	that initiated events	1	c									-	
90,	icate be executed physicien and s the burial-transit	EX	resulting in death) Last	- 1	Due to (or as	a consec	quence of):								
68760,	physic the t	edicai			d										
Вох	death certii e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fet	el death 3	□Ectopic □ Other (pregnancy (specify)				23d. Date of Month		ry Day Year
P.0.	that the	H.	Part II. Other significant co	nditions c	ontributing to death b	ut not res	sulting in the	underlying	g cause give	en in Part I.	23e. Did	tobacco	use contribut	e to th	e cause of death?
Division of Vital Records,	w requires that the been signed by the should be detache	d by	DIABET	ES ME	LLITUS						1 🗆	Yes 2	□No 3□] Prob	ably ************************************
000	sh de	Completed	HYPERT	ENSIO	N						24a. Wa	s an opsy	24b. Wer	autor	osy findings available
Be	The lav	mo									per 1 Yes	formed?	deat	h?	2□ No
'ital	iician: Th certificate rector, pag	Bec	25. Was case referred to m examiner?	edical							ath (Check only		-		
of V	hys this	은	1 ☐ Yes 2ĀĀNo				ER/Outpati		DOA Oth	er: Nursing I	Home 5 Res			Specify	"
LC C	و 16 م	tion:		ending vestigation	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury		Wor	k? Yes 2 □ No	20d. Describe	riow inju	iy occurred		
isi	Attender death	fica	3 ☐ Suicide 6 ☐ G	ould not be	28e. Place of Inj	ury - At h	jome, farm, s	street, fact	ory, office					r Rura	l Route Number,
á	s after s after of in b	Certification;	4 Homicide		building, et	c. (Speci	''y)				City of 1	own, State	e) 		
	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: All completely filled in by the fu	Medical (29a. Certifier 1 △ Ce (Check only one) 2 ☐ Me	tifying Ph dical Exan	ysician: To the best niner: On the basis of and manner st	f examin	owledge, de ation and/or	ath occurre investigati	ed at the tin on, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause(s e, date an	and manne d place, and	r as st due to	ated. the cause(s)
	To th within To the compl	Me	29b. Signature and title of c	ertifier	14			2	9c. Licens				ite signed (N		
	3) BW	,	77				D	51520		U	7-08	~ (
	B		30. Name and address of po Bahram P		completed cause of o	leath (Ite Old P	m 23a) (Type Branch A	e, Print) Venue	#409	Clinton,	Maryland	2073	35		
4		to	31. Date filed (Month, Day.				Ante San				-				
	Sta Registi		111 1 1 200		Course 16	A	The same								

	·		1 - For State Registrar		aryland / E	epartme Certifica	nt of H te of L	ealth a	nd Me	ental Hyg	iene g. No. 2	005	24113
Г	Physici	an	1. Decedent's Name (First, Middle, La	,					2	2. Date of Deat Month	Day	Year	3. Time of Death
	/Medi	cal	Porfirio Lopez 4a. Facility Name (If not institution, giv				T			July		2005	3:27 P M
	Examir	er	Shady Grove Adver			4b. City		Location of ockvi				nty of Death ontgom	orv
	Funeral		5. Social Security Number 6. S	iex 7. Ag	ge (In yrs. last birt		er 1 Year	If Under 2		B. Date of Birth			place (State or Foreign ntry)
	Director		216-21-5045 Usual Residence of Decedent	⊉ M 2□ F	57	Yrs. Months	Days	Hours	Min.	B. Date of Birth (Month, Day, 19	,1947	Nic	aragua
	laryland ahow	5	10a. State 10b. County MD Montgoi		10c. City, Town							1	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the N	rect	MD Montgor	nery		German	ip Code			11	Og Citizen	of What Coul	
	3a or	Ö	12417 Hickory Tre	ee Way #D		101.2	.p 0000	20874	4		Nican		indy:
980	a within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28e-f ahow The Medical Exerginar pust be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2(X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1 Tyes 2 Note: 1 Yes, Give Year or Dates:	?			spanic Origi n, Mexican, Specify:		ify Yes or No- ican, etc.)	14. F	lace - Americ Black, White,	
Maryland 21215-0036	within 72 ho ene. than "natur re Medical I	Completed	15. Decedent's Elementary/Secondary (0-12)			Decedent's Usi (Give kind of w life. DO NOT	ork done a	lurina most (of working	,	16b. Kind of	Business/In	dustry
21	filed w Hygier ther th		12			Dı	river	10.14-1-1		F:		tomob	ile
land	0 = 0 \$	To Be	17. Father's Name (First, Middle, Last) Cruz Lopez	,			,			First, Middle, A ila Ros		ame)	
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a once.		19a. Informant's Name/Relationship (Norma Sanchez Lo							Route Number, #D, Ger			
Baltimore,	ages 1 au nt of Hea :: If itam		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □		20b. Place of cemeters	Disposition (Na y, crematory or	ame of other place	9)	June 200	te 2	0c. Locatio	n - City or To	own, State
altin	Department Properties mportent any injury 2006.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		ALL S	ouls Ce	nd Addres	s of Facility	DeV	ol Fune	ral H	antowr ome, 1	0 East
	205 29		1 TRACY 4	Tule	/	Deer F	ark I	rive,	, Gai	tnersbu	rg, M	D 2087	/ 7
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	d the death. Do n ine. SEPS a consequence of	15	de of dying	g, such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
8760,	death certificate be executed a ettending physician and id for use as the burial-transit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. METASTA Due to (or as		EUROE	NDOC	RINE	E C	ANCEI	2	-	
387	physi physi the b	dice	•	d		_	-					- 1	
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s						Date of delive	ory Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of PANCYTO PE		out not resulting in	the underlying	cause give	n in Part I.				ontribute to th	ne cause of death?
Division of Vital Records,	@ _ _ @	Completed								24a. Was ar autopsy perform	ed?	o. Were auto prior to cor death?	psy findings available impletion of cause of
tal	icien: Th certificate rector, pag	0	25. Was case referred to medical		-			26 Place o	of Death (1 ☐ Yes 2 Check only one	No No	1 🗆 Yes	28 No
<u> </u>	y s	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/Out	patient 3 D	OA Othe	p-		5 🗆 Reside		Other (Specifi	y)
o uoi	ng The The		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	Jry 28b. T	ime of jury M	28c. Injury Work 1 🗌 Y	-	28	d. Describe ho			
Divis	al or Atte after des Diracto d in by th	Certification:	3 Suicide 6 Could not be determined	286. Place of In	jury - At home, far ic. (Specify)	m, street, facto	ry, office		28	f. Location (Str City or Town,	eet and Nui State)	nber or Rura	l Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best niner: On the basis o and manner st	of examination and	death occurred for investigation	at the time, in my op	e, date and inion, death	place, and occurred	d due to the ca at the time, da	use(s) and te and place	manner as st e, and due to	ated. the cause(s)
	To th within To the	Me	29b. Signature and title of certifier			29	c. License	number		29	d. Date sign	ned (Month,	Day, Year)
)			M.i) .			DE	3594	41	ĺ	JUI	y 5	, 2005
	3		30. Name and address of person who PVRAW P. MATI	completed cause of c	death (Item 23a) (Wal-	TD 21	00	Rod			0 20852
	Sta	te	31. Date filed (Month, Day, Year)	39 Registr	rar's Signature	14,00	· V 143	(0)	VIC	1-04	cvi4 (<u> </u>	1 200 L
	Registr	ar	JUL 0 8 20	05 House	15 K	DORAGE							

			1 - For State Registrar		State of	Maryla	nd / Dep		t of H	lealth a	and N	Mental Hy	giene				
			Decedent's Name (First, Michael Control of the	ldle, Last)				Tuncat	e or i	Jeani		2. Date of De	Reg. No.	. 0 0	5	2 1 1	dant
	Physici		Pearl S.	Levy								Month July	Day	200	ear	0. 0.0	М
	/Medic Examir		4a. Facility Name (If not institu		treet and nun	nber)		4b. City,	Town, or	Location	of Death	July		County of		2:20	_a
	ZAGIIII		Holy Cross Nu				iter	Burto	onsv	i 11e				Monts		rv	
	Funeral		5. Social Security Number	6. Sex			. last birthday,			If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h			ace (State or try)	Foreign
	Director		063-20-0737	וו ו	M 2⊠F		80 Yrs.	Willia	Days	riours	IVIIII.	June 30	, 19	25 1	Broc	klyn,	NY
	and w		Usual Residence of Decedent 10a. State 10b. Cour	tv		10c. C	ity, Town or L	ocation							11/	Od. Inside City	. I Imite
	Aaryli f sho	5					•									1 ☐ Yes 2	
	the tage	ect	Maryland Mont 10e. Street and Number	gomer	У	51	lver S	10f. Zip	Code	-			10g. Citize	en of Who	ot Coun		
	3a or	ā	10308 Lesie St	reet					0902				U.S		at Obdin	uy:	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be incitified at	Funeral Director	11. Marital Status		2. Was Dece	dent Ever in l	J.S. 13.				igin? (Sp	ecify Yes or No- Rican, etc.)		4. Race -	Americ	an Indian,	
9	after or Ite		1 ☐ Never Married 2 ☐ M	arried	Armed For	2 🔯 No						Rican, etc.)		Black, 1	White, 6	etc.	
8	ours iral',	d by	3 ☑ Widowed 4 □ Divord	ed	If Yes, Giv Year or Da	ites:		1 Yes	ZELI NO	Ѕреспу:			5	Specify:	Whi	te.	
5	72 h natu	Completed	15. Deced (Specify only hig				16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ation during mos	t of work	ing	16b. Kind	d of Busin	ess/Ind	ustry	
12	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)	1		se retired)			ъ				
2	liled v Hygie ther t	ပိ	12th 17. Father's Name (First, Midd	a / ast)			Home	maker		10 Metho	ar's Nome	e (First Middle,		mest	LC		
auc	d be formal l	Be	Julius Steinb										Maluen S	umame)			
7	should id Me mark matik	2	19a. Informant's Name/Relation		a Print)		19h Maili	no Address	/Street	Libb		al Route Numbe	r City or	Tours Sta	to 7in	Codel	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Madical Examination unit be notified at ance.		Stewart Levy		•							Spring,			. ,	,	
Baltimore,	f Head the street		20a. Method of Disposition			20b.	Place of Dispo cemetery, cre					Date		ation - Cit			
Ë	Page III		1 ☑ Burial 2 ☐ Crematio 1 ☑ Donation 5 ☐ Other		moval from S	naie ;					11177	7,2005	01	OW	Mar	rland	
alti	mit. partm porta y inju		21. Signature of Funeral Servin				2:	2. Name an	d Addres	s of Facilit	y Hir	r,2005 nes-Rina	ldi :	Funer	ral	Home,	Inc.
m	8 9 E 8 8		Alexelen T	Me	lad	2						Ave. S					
STATE STATE	Pnysician /Medical Examiner	ler	23a. Par1. Enter the disease, sock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	or compile st only one	Metas Due to (a	ich line.	Breast quence of):			g, such as	cardiac	or respiratory an	rest,			Approximate Interval Betwe Onset and De	
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause Underson or must that initiated events resulting in death) Last	c.	Due to (d	or as a consec	quence of):										
.O. Box	that the death certific ed by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 🕱 Unknown	23	1 ☐Live bi	ome of pregn rth 2 □ Feta Int at time of o wn	al déath 3	⊒Ectopic pro ☐ Other (spe					23	d. Date of Month		y Day Ye	ar
rds, P	sign sign d be	by	Part II. Other significant cond	tions cont	ributing to de	ath but not res	sulting in the u	nderlying ca	ause give	n in Part I.						cause of dea	
Records,	e law requ has been je 2 shoule	ompieted										24a. Was a autops	sy	24b. Were prior deat	to com	sy findings av pletion of cau	ailable se of
<u></u>	yslclan: The is certificate hadirector, page	e Co	OF Man ages relevant to									1 ☐ Yes	2X No		Yes 2	!□ No	
Vital	sicla certi	o Be	25. Was case referred to mediexaminer? 1 ☐ Yes 2X No		spital:] ED/O		Othe	r		(Check only or			-		
Division of	를 를 끊	-	27. Manner of Death 1 X Natural 5 ☐ Pend	ling tigation	28a. Date o		28b. Time of Injury		Bc. Injury Work	4 L2 NU		me 5 Resid			Specify)		
Divis		Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined	28e. Place buildin	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, str	eet, factory	, office			28f. Location (S City or Town		Number o	r Rural	Route Numbe	τ,
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edicai	one)	ii cxamine	cian: To the i er: On the ba and mann	sis of examina	owledge, death ation and/or in	vestigation,	in my op	inion, deat	d place, a	and due to the c ed at the time, d	ate and pl	ace, and	due to t	he cause(s)	
	Son Temporal	Σ	29b. Signature and title of certi	er (24	~ O I		0		License			2	9d. Date s	signed (M	onth, D	ay, Year)	
1	10+"		- Meura	_ 71	rotel	men			02534	48		J.	uly 6	, 20	05		
	10		30. Name and address of person										_				
			Marcia Goldmar 31. Date filed (Month, Day, Yea		22 🕮 0	gietrade Sign	oturo		ad, l	North	Pot	omac, M	aryla	and			
	Sta Registr		JUL 0		5	ever 1	s so	acks.									

			4 101	epartment of Health and M Certificate of Death	ental Hygiei Reg.	/11115	24115
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> BERTHA W. LINDSAY		2. Date of Death	Pay 2005	3. Time of Death 2:05am ^M
	Examir		4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL	4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONT.	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye. MAR . 14	9. Birthr 1914 S.	lace (State or Foreign
	Maryland f show	ŏ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD	or Location ATTSVILLE		1	0d. Inside City Limits 1 □X es 2 □ No
	death with the Maryland oms 23e or 28e-f show	i Director	10e. Street and Number 500 CHILLUM ROAD #102	10f. Zip Code 20783	10 <i>g</i> .	Citizen of What Cour	ntry?
036	72 hours after death natural', or Items 2: olded Examination	by Funerai	11. Marital Status 1 Never Married 2 Married Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto F □ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
Maryland 21215-0036	id within 72 ho giene. er then "natu	Completed	(Specify only highest grade completed) ((decedent's Usual Occupation Give kind of work done during most of workin ife. DO NOT use retired) DOMESTIC	16b.	Kind of Business/Inc \mathbf{PVT} .	dustry
/land	should be filed nd Mental Hygi i marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) WILLIAMS WATTS	18. Mother's Name MARY	(First, Middle, Maid DENDY	en Sumame)	
, Mar	and 2 sho saith and I n 27 is me			Mailing Address (Street and Number or Rural 0 0 GORMAN AVE #21			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show the injury or other traumatic event, It a Marical Examiner must be multiled at ODGs.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State / cemetery,	crematory or other place)	09-05 L	ANGOVER 11.	
8760,	death certificate be executed e attending physician and of for use as the buriar-transit	dical Examiner	23a. Part1. Enler the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) C. Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) C. Due to (or as a consequence of)	hellita, Type 2 i uker Vaicular dis	2 .		Approximate Interval Between Onset and Death
P.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
Ś	quires that n signed b uld be deta		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacci	use contribute to the	e cause of death?
Vital Record	hysicien: The law requires that the nis certificate has been signed by the director, page 2 should be detach	Completed			24a. Was an autopsy performed?	prior to con death?	sy findings available apletion of cause of
Division of Vit	ding Pl h. After ti funera	Certification; To Be	25. Was case referred to medical examiner? 1	ne of 28c. Injury at Work? M 1 Yes 2 No	e 5 Residence	and Number or Rural	
	Hospitel 4 hours Funeral ely filled	edical Ce	29a. Certifier (Check only page) Medical Examiner: On the basis of examination and/or and manner stated and manner stated and manner.	death occurred at the time, date and place, are prinvestigation, in my opinion, death occurred	nd due to the caused d at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier.	29c. License number		Pate signed (Month, D	Pay, Year)
,	63		30. Name and address of person who cumpleted cause of death (Item 23a) (Ty	pa. Print). 6525 Belca	est Rd	Ha	Hsville
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 8 2005 32. Registrar's Signature			/ud. 20	782.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>005</u> **Physician** Year 16, JULY 01:15 a.™ Alonzo Summers Lipscomb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CUMBERLAND ALLEGANY Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 27, 1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** MIM 2□F Yrs. Director 233-56-2663 70 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 le marked other than "neturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be ricitlised at Director 1 ☐ Yes 2 ▼No Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pleasant Dale Rd. 26704 **USA** Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 D No. 1757 If Yes, Give Year or Dates: 1963 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: à Specify: 3€Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If item 27 I e marked other than "r any fijury or other treumatic event, I're Med gones. Dept. of Elementary/Secondary (0-12) College (1-4or 5+) Laborer 8 Natural Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George P. Lipscomb Elva O. Schrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo J. Lipscomb P.O. Box 16 Augusta, WV 26704 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Scarpelli F.H.PA Crematory 1 Burial 2XXCremation 3 Removal from State 7/16/05 ^¹ 4 □ Donation 5 □ Other (Specify) Cumberland, Md. 2. Name and Address of Facility
McKee Funeral Home Inc. 21. Signature of Funeral Service Licens P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrhythmic disease or condition resulting in death) minutes /Medical Due to (or as a c * sequence of) **Examiner** Artery Disease 10 years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Renal Stage 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.O. Records, Division of Vital To the Hospitel or Attending Physicien: death. Director: / within 24 hours af
To the Funerel D
completely filled in

4 | Homicide

(Check only one)

29a. Certifier

Medicai

State Registrar

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 031875 d cause of death (Item 23a) (Type, Print) Suite 308 Cumberland, MD 21502 12 Seton 3 Registrar's Signature 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			1 - For State Registrar	State of N	Maryland / [rtment of Hea tificate of De			_		
	Physici		Decedent's Name (First, Middle, La JONATHAN	SEBAST	IAN	MYE		,4111	2. Date of De Month June		5 Par	37 into of Death 7
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and numbe	or)		4b. City, Town, or Loc	cation of Death	buile	4c. County of E		TT. 44V
	Funeral	٠	Suburban Hos 5. Social Security Number 6. S	pital 7.	Age (In yrs. last bii	rthdav)	Bethe:		8 Date of Bin	Monte		ery ce (State or Foreign
	Funeral Director		219-32-6333	X M 2□F		Yrs.	Months Days H	lours Min.	8. Date of Bird (Month, Da Oct. 1	0,1961 T	Country	DC
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				10d	. Inside City Limits
	e Mary	ctor	MD Frede	rick	Fr	ede	rick					1 ∄ ¥es 2 □ No
	th with the 23a or 28	al Director	10e. Street and Number 7199 Cimarro	n Ct Un	itD		10f. Zip Code 2170	3		10g. Citizen of Wha		/?
980	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show Jigal Evar, if writnest be indiffied at	Completed by Funeral	11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? ∑∛ No	l If	as Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2 No S	nic Origin? (Sp Mexican, Puerto pecify:	ecify Yes or No Rican, etc.)		Vhite, etc	>
21215-0036	within ne. hen "	mpieted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4a		(Give k	ent's Usual Occupation ind of work done during O NOT use retired) S Operate	ng most of work	ing	16b. Kind of Busine	mery	CO.
d 2		Be Co	12 17. Father's Name (First, Middle, Last,)					e (First, Middle,	Publio Maiden Surmarne)	C SC	choots
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Mar	gas 1 and 2 should be fillad the Health and Mental Hyg If item 27 is markad othe or other treumatic event,		19a. Informant's Name/Relationship (Teresa Myers-H	* * * * * * * * * * * * * * * * * * * *	ister 3	. Mailing	Address (Street and Baptist	Number or Rura Rd Ta	al Route Number	er, City or Town, Sta.	te, <i>Zip C</i> o 1787	ode) 7
more,	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tre once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		20b. Place o		ition (Name of atory or other place)		Date	20c. Location - City		
Itim.	nit, Paga partment o fortant: If injury or		* 4 □ Donation 5 □ Other (Specif	n //	Methy	/ Fn	rl Svcs		2005	Alexand		
Ba	Depare Important in any ire		21. Signatur of Funeral Service Lice	XXIII	ukl		Name and Address of					
			23a. Part1. Enter the disease or com shock, or heart failure. List only	one cause on each	iline.					rest,	ln.	pproximate iterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		_	IC HEART	DISEA	SE			nset and Death
5	Examiner		Cogupatiath, list conditions	bue to (or a	as a consequence	01):						
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29-03 .0. Box 6	ne death certif the attending thed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Da	ay Year
S, P	res that thisignad by	by Pl	Part II. Other significant conditions of	ontributing to death	but not resulting in	n the un	derlying cause given in	Part I.	23e. Did to	bacco use contribut		
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al Recor	The ate h page	Completed							24a. Was autop perfo	rmed? prior	e autopsy to compl h? Yes 2	r findings available letion of cause of
C+h	Physiclen: r this certificated director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpa	tient 2 XER/Ou	itnationt			Check only o	ne) dence 6 □Other (S	Connection)	
n of	aling Phys	on: T	27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of In (Month, L		Time of	28c. Injury at Work?			now injury occurred	эреспу)	
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S. J.	s after deal s after deal sl Directors ed in by the	Certif	4 Homicide determined	building,	etc. (Specify)	, 5.10	ot, ractory, ornes		City or Tow	m, State)	nurarn	oute runiber,
Myus, Sohruth Division of Vita	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the be niner: On the basis and manner	of examination an	e, death d/or inve	occurred at the time, destigation, in my opinio	late and place, on, death occurr	and due to the o	cause(s) and manne date and place, and	r as state due to the	ed. e cause(s)
		Σ	29b. Signature and title of certifier				29c. License nui			29d. Date signed (M	onth, Day	y, Year)
	10		30. Name and address of person o	mpleted cause of	death (Item 23a)	(Type P	rint) 005	2180		61241	700	15
<u></u>			Brendan J. Că	rmody,	MD 8600	01	d Georget	town R	d Beth	esda, MI	20	814
(1)	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 8 20	32 Regis	strar's Signature							
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			State of Maryland / Department	artment of Health and Mental Hy	giene
	ŧ		State of Maryland / Depart AMEND#18perFH7/18/05, BW, McCo 1- State of Maryland / Depart AMEND#18perFH7/18/05, BW, McCo Cell Common Co	rtificate of Death	Reg. No 2005 24 18
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath 3. Time of Death Day Year
	/Medic Examin		Harry T. Monroe 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2, 2005 3:15 a M
	Examili	EL	Manor Care Wheaton	Wheaton	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		
	Director		230-10-9756 165 M 2 F 86 Yrs.	Nov. 1	8, 1918 Virginia
	yland sow		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery Wheaton		1 ☐ Yes 2 🖾 No
	with th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath v	erai	2809 Weisman Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was December of Hispanic Origin? (Specify Vec or No	U.S.A. 14. Race - American Indian,
(0	r itam	Funerai	1 Never Married 2 Married 1 XYes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
903	72 hours atter death with the Maryland "natural", or itams 23a or 28e-1 show byteal Examiltar must be it willed at	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White
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12	within iene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 4th Pair		M-N.C.P.P.C.
bc	e tilec othe vant,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
ylaı		ToE	Frank Monroe	Mamie Unk	MAMIE UNKNOWN
Maryland 21215-0036	2 2 2 2			ng Address (Street and Number or Rural Route Numb	
	of Health Itam 27 I			Weisman Road, Wheaton, M position (Name of matory or other place) Date	aryland 20902 20c. Location - City or Town, State
Baltimore,			1 23 bullar 2 [] Cremation 3 [] Removal noin State	à la companya de la c	Rockville, Maryland
alti	permit. Page Department of Importent: If any injury or once.			2. Name and Address of Facility Hines-Rin	
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п			234. Part1. Entily the disease, or complications that caused the death. Do not en shock, or leart failure. List only one cause on each line.		rrest, Approximate Interval Between Onset and Death
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	be sit	iner	if any, leading to immediate cause. Enter Underlying		
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icalE	d		
9	rtificat ng phy as th	9	IF FEMALE:		
Вох	eath certific attending p	lan/N	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy	23d. Date of delivery Month Day Year
0.	at the dea by the a tached f	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	☐ Other (specify)	monar bay rou
0	s that i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
rds	w requires been sign should be		Diabetes, hypertension, chronic obstr	ructive pulmonary	Yes 2□No 3□Probably 4⊠Unknown
Records,	law re as be	Completed	disease, myelodysplastic syndrome, ch	auto	osy prior to completion of cause of
E B	: The tay cate has ; page 2			perfo 1 □ Yes	ormed? death? 2☑No 1☐Yes 2☐No
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sior	ttending F death. ctor: Atter y the funera	atio	2 Accident investigation	M 1 Yes 2 No	
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	ne Hos n 24 h na Fur sletely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	nvestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			1700000	My 00057630	4-0-05
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Anuradha Arun, M.D. 10301 Georgia A	. _{Print)} ve. Ste# 209 Silver Sprin	ng, MD 20902
	Sta	ate			
	Regist		JUL 0 7 2005 Angus S. B.	nade	

			For State	State of I	Maryland / Dep	artment of H		and M	, ,		200-	
			Registrar 1. Decedent's Name (First, Middle, Last)			runcate or t	Deain		2. Date of Deat	eg. No.	2005	21/20/19
	Physici	an	Joseph Michael Mitche	17					Month	Day	Year	January of Delitu
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or		(D	July 5	, 200	ounty of Death	9:00 P M
4	Examin	er			91)		Location o	n Death				
			Montgomery Hospice-Cas 5. Social Security Number 6. Sex		Age (In yrs. last birthday,	Rockville If Under 1 Year	If Under 2	24 Hrs	9 Data of Birth		ntgomery	lane (0)
۲.	Funeral Director			M 2 F	Ven	Months Days	Hours	Min.	8. Date of Birth (Month, Day)	Year)	Cour	**
			Usual Residence of Decedent		42				June 13,	1963	Penns	ylvania
	land		10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City Limits
	Many -∱sh	ţō	Maryland Prince Geo	me¹s	Riverda	10						1 ☐ Yes 2☐ No
	the 28a	Director	10e. Street and Number	rge b	Idverda	10f. Zip Code			1	0g. Citize	on of What Cour	ntry?
	3a o		6708 Third Street			20737	7				US	77.
	ms 2	Funeral	11. Marital Status	2. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Spe	ecify Yes or No-	14	I. Race - Americ	an Indian,
က	after a		1 X Never Married 2 Married	Armed Force	os? ⊡ t No			, Puerto	Rican, etc.)		Black, White,	
21215-0036	al', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1 ☐ Yes 2 🔀 No	Specify:			S	pecify:White	
P P	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occupa	ation	t of work	ina	16b. Kind	d of Business/In-	dustry
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7	gien er th	Con		5+		agement				Ech	ucation	
b	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exertiret mast be notified at	Be (17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, I	Maiden S	umame)	
<u>a</u>	should bind Ment marked	2	Joseph A. Mitchell				Marg	aret	Andyshak			
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street a	and Numbe	r or Rura	I Route Number	City or T	Town, State, Zip	Code)
	and and n 27		Joseph A. Mitchell/ Fa	ther	66]	indiana Stre	et, Har	mer C	ity, PA 1	5748		
Baltimore,	~ f a =		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	om aval from Cta	20b. Place of Disponentery, cre	osition (Name of matory or other place	e)			20c. Loca	ation - City or To	wn, State
Ĕ	Pages nent of Pages ant: If its		'4 □ Donation '5 □ Other (Specify)	emoval from Sta	Metropolita	n Crematory		Jul. 20	y ,	levano	dria, Vir	rinia
a	permit. Departn Imports any inju		21. Signature of Funeral Service License	е	F ₂	2. Name and Addres	s of Facility		al Nome T	-	ALLEY VIII	d-1 secs
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			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	ations that cause on each	sed the death. Do not en	ter the mode of dying	g, such as	cardiac c	or respiratory arm	oring,	, MD 2090	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		y-Spread Metas	tatic Hodok	in'e Ts	umohou	ma			Onset and Death
1	/Medical	1 1	resulting in death)		as a consequence of):	carrie maga	шът	ynigh ioi	ilid.			
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8760,	cate be executed physician and the burial-transit	dical	d									
9	E C3 0	ledi										
Вох	at the death certific by the attending patached for use as	Physician/Me	23b. was decedent pregnant		me of pregnancy 2	Ectopic pregnancy				23	d. Date of delive	ry
	0 @ 2	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	t at time of death 5	Other (specify)					Month	Day Year
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s, F	The law requires that the ste has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions con	tributing to deat	h but not resulting in the u	nderlying cause give	en in Part I.		23e. Did tot	acco use	contribute to the	e cause of death?
Ë	w require been sig should b								1 □ Ye	s 2 ½	No 3□Prob	ably 4 □Unknown
Record	s been s been s shoul	Completed							24a. Was a		24b. Were auto	osy findings available
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Vital			25. Was case referred to medical				GC Diago	of Donth		No No	1 🗆 Yes	2 No
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of		-	27. Manner of Death	28a. Date of I	njury 28b. Time o	f 28c. Injury	at	-	28d. Describe ho			7
O	nding f th. : After s funer	텵	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year) Injury	M 1 🗀 🗅	<br Yes 2.∐.N	Vo				
Division	Attending r death. actor: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At home, farm, st	reet, factory, office		1	28f. Location (St	reet and I	Number or Rura	l Route Number,
á	afte Dire	ert	4 Homicide	building,	etc. (Specify)				City or Towr	n, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	a C	29a. Certifier 1 Certifying Phys	ician: To the be	est of my knowledge, deat	h occurred at the tim	ne, date and	d place. a	and due to the ca	ause(s) ar	nd manner as st	ated.
	e Ho e Fui e Fui	edical	(Check only 2 Medical Examination)	er: On the basis and manner	s of examination and/or in	vestigation, in my op	oinion, deat	th occurr	ed at the time, d	ate and p	lace, and due to	the cause(s)
	Fo th within Fo th compl	Me	29b. Signature and title of certifier	11/	\mathcal{I}	29c. License	number		2	9d. Date	signed (Month,	Day, Year)
	F>F0	/	1 AM	1/1	-	NU	121	18		.Tr 17.	y 6, 2005	
	19		30. Name and address of person who co	moleted cause of	of death (Item 23a) (Tues	Print)	101	0		Jul	., ZOO	
	1		Charles Harrison, M.D.				11. **	m 200)EE			
	Sta	to.	31. Date filed (Month, Pay, Year)		uncaster Mill I strar's Signature		тте, М	10 ZUE	ວວວ			
	Registr		31. Date filed (Month, Day, Year) 7 20	05	strar's Signature	new						

			For	State of	Marylan					and M	-	-		01.100
			1 - State Registrar 1. Decedent's Name (First, Middle,	l act)		Cei	rtificate	e or i	Jeain -		2. Date of De		005	3. Time of Death
	Physic	an	Mary Lillian McMaho								Month	Day	Year	рм
	/Medi Examir		4a. Facility Name (If not institution,		er)		4b. City.	Town, or	r Location o	of Death	July 5	-	Dounty of De	11:00
	Examir	er	Montgomery Hospice				Rock						ntgomer	
	Funeral		3 3 1	. Sex 7.	Age (In yrs. I	last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th		irthplace (State or Foreign Country)
ш	Director		577 - 20-1761	1 □ M 212 F	84	Yrs.	WOTHIS	Days	Hours	(April 21			shington, DC
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	the Marylar 28e-f ehow	٥												1 □ Yes 2 □ No
	28e-	rect	Maryland Montgo 10e. Street and Number	mery	5	<u>Silver</u> S	10f. Zip	Code				10g. Citiz	en of What C	Country?
	h with	Funeral Director	3580 Gleneagles D	rive			20	0906					USA	
	deat	ner	11. Marital Status	12. Was Decede			Was Deced	lent of H	ispanic Original	gin? (Spe	cify Yes or No	- 1		nencan Indian,
98	or It	y Fu	1 Never Married 2 Married	1 ∏ Yes 2y If Yes, Give	∑ No		1 ☐ Yes 2		Specify:	,	mount, oto.,		Specify: Wh	
21215-0036	d within 72 hours after death with the Maryland Jiene. Ir then "neturel", or Items 23e or 28e-f ehow Its Marical Examiner (unt be naillied at	d by	3 Widowed 4 Divorced	Year or Date	es:	16a Dasa	dent's Usua	10	-41					
7	in 72	lete	15. Decedent's (Specify only highest	grade completed)		(Give	kind of wor DO NOT us	k done d	durina mosi	t of workir	ng	160, Kin	d of Busines	s/Industry
212	d within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Admin	istrati	ive A	ssista	nt		D.C.	Public	Schools
	ent,	BeC	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle,			
/lar		ToE	Percy Soper						Mar	y Vinc	cent Mona	aco		
Maryland	0 60 00 10	0	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	r or Rura	Route Number	er, City or	Town, State,	Zip Code)
	s 1 and 2 of Health item 27 l		John K. McMahon/ Hu 20a. Method of Disposition	sband	20h P	3850 (lace of Dispo	Glenear	les	Drive.		r Spring			- T Chair
יסר	ages If ite		1X□ Burial 2 □ Cremation 3		ate C	emetery, crei	natory or ot	ther plac		Jul	y 8,			r Town, State
Baltimore,	Definit. Pages Department of P mportent: If ite any injury or of	1	 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		Piou	nt Olive					005	Washii	ngton,	DC
Ba	Depar Impor any ir		senso	2 Oct	Day	F: 50	rancis 30 Univ	J. O versi	ollins ty Blv	'Funer d, W,	ral Home Silver S	Inc. Spring	, MD 209	901
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cau by one cause on eac	sed the death h line.	. Do not ent	er the mode	e of dyin	g, such as	cardiac oi	r respiratory ai	rest,		Approximate Interval Between
	Pnysician	7.9	Immediate Cause (Final disease or condition	a_Cerebro	vascula	r Accide	ent							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):								
	120	ia l	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	be executed ician and burial-transit	Exa	resulting in death) Last	c Due to (or	as a consequ	uence of):								
8760,	ys e	Ical		d										
9	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal	death 3	Ectopic pre					23	3d. Date of de Month	elivery Day Year
P.O.	that lhe de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregnan 9⊟ Unknow	t at time of de n	eath 5L	Other (spe	эспу)						
	requires that lhe een signed by th hould be detache	by Pr	Part II. Other significant condition	s contributing to deat	h but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	obacco us	e contribute	to the cause of death?
ecords,	w requires been sign should be										101	res 2 🎗	No 3□F	robably 4 Unknown
000	e law re has bee je 2 sho	plet									24a. Was		24b. Were a	utopsy findings available completion of cause of
α	The ate h page	Completed									autop perfo	rmed?	death?	
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only o	пө)		
of	this al dii	5	1 Yes 2X No 27. Manner of Death	Hospital:		ER/Outpatier			4 🗀 Nu					ecity Hospic e
no	ding h. After fune	llon	1 XNatural 5 ☐ Pending		Day Year)	28b. Time of Injury	M	Bc. Injury Work	≀aτ ⟨? Yes 2.⊟N		8d. Describe h	iow injury	occurred	
Division	I or Attending after death. Director: After I in by the funer	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of	Injury - At ho	me, farm, str					8f. Location (S	Street and	Number or F	Rural Route Number,
D.	or or or	Certification:	4 Homicide	building	, etc." (Specify	/)					City or Tou	m, State)		
	To the Hospitel or Atten within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be eminer: On the basi and manner	s of examinat	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the d	cause(s) a date and p	ind manner a place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title di certifier				29c.	License	o number			29d. Date		ith, Day, Year)
)			14/	~ ~	7			D3563	85			701-	104	, 2005
	10		30. Name and address of person with Joseph Kaplan, MD.	6001 Munca	,			illa	MD 20	1855				
	Sta		31. Date filed (Month, Day, Year)		istrar's Signal				THU ZU					
	Regist	al	0	- Sold	ELISON S	as for	ALTER TOPICS							

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artmen ertificat			and M	-	giene Reg. No.'		21.10.
П			1. Decedent's Name (First, Middl	e, Last)						2. Date of De Month	$\overline{}$	2003	- Time of Death
	Physici /Medio		James W.	McGi	ın, Jr.	,				July 3		005	10:30 P M
	Examir		4a. Facility Name (If not institution	n, give street and numb	er)	7.		Location of			4c.	County of Death	
			Potomac Valley					Chase If Under:	24 Hrs	O Data of Bir	Mo	ontgomer	×
	Funeral Director	Ì	5. Social Security Number 029-16-6269	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birthday 79 Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da July 1	т У <i>Үөаг)</i> 7 1 9	25 Mass	place (State or Foreign htry)
			Usual Residence of Decedent		.,,	i				oury r	, ,	23 1100	•
	ylanc how	[10a. State 10b. County	-	10c. City, Town or L	ocation							Od. Inside City Limits
	Ba-fs	cto	Maryland Montg	omery	Chevy C	Chase							1 XYes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip					10g. Citiz	zen of What Cou	ntry?
	e 23a	rai	4450 S. Park A			Was Dass	208		-:-0 /0	-4-3/		USA	and the second s
	ter de Item	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force	ent Ever in U.S. 13.	If Yes, spec	ent of Hi	n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	 Race - America Black, White, 	
920	urs af		3 Midowed 4 □ Divorced	If Yes, Give Year or Date	www.i/Korea	1 🗆 Yes	2 ∑ No	Specify:				Specify: Whi	Lte
Ö-0	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show he Madical Enantirat must be notified at	Completed	15. Deceden	t's Education st grade completed)	16a. Dec	edent's Usua e kind of wo	al Occupa	ation	t of worki	na	16b. Kir	nd of Business/In	dustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4	life.	DO NOT us	se retired)	O WOIKI	,,g	II G	D . 1	
2	led w lygier her th		17 Fetheric blame /First bliddle	(201)	E	ngine	er	10 Matha	ula Nama	(Fire Middle			Service
anc	ntal Hed of	Be	17. Father's Name (First, Middle,							(First, Middle, Connell		Sumame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at ance.	Ť.	James W. McG:		19b. Mai	ing Address	(Street a					r Town, State, Zig	Code)
<u>≅</u>	od 2 s lith ar 27 is r treu		Maura McGinn/		1							Virgini	
ē,	s 1 ar f Hea item othe	i	20a. Method of Disposition		20b. Place of Disp	osition (Nar	ne of			Date		cation - City or To	
E	Page nent o ant: If		1 ☐ Burial 2 🏹 Cremation 1 ☐ Donation 5 ☐ Other (S		Metropoli	tan Cı	cemat	torv	Մuly շ	กก็ร	A1e	x., Virg	rinia
Baltimore,	permit. Departmimporte any inju		21. Signature of Fundral Service	Lightsee	2	2. Name an	d Addres	s of Facility	y De V	ol Fune	ral	Home	
<u> </u>	89788		plus A	Sell				Wasi	hing	ton, D.	C. 2	Home 0007.W.	
	rnysician /Medical Examiner	ıer	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tary, leading to inmediate cause. Enter Underlying Cause (Disease or injury	a	ARD to PULM o as a consequence of): ALLURE To as a consequence of):	NARY	Αf			respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	th certificate be executed ending physician and r use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or d.	as a consequence of):						T		
Box	75 a 5	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pr □ Other (sp					2	3d. Date of delive Month	ery Day Year
rds, P	w requires that been signed I should be det	ed by P	Part II. Other significant condition	OF LARY	NX		ause give	en in Part I.		23e. Did to		se contribute to the	ne cause of death?
Division of Vital Records, P.O.	The law requirate has been page 2 should	Complet	Drshargin	STATUS PO	ST GTUBE	PLAC	EME	NT		24a. Was autop perfo	sy	24b. Were auto prior to co death? 1 Yes	psy findings available impletion of cause of
/ita	Attending Physiciant: The react. r death. sector: After this cartificate by the funeral director, pag	Be	25. Was case referred to medica examiner?							(Check only o			
5	this o	2	1 ☐ Yes 25 No	Hospital: 1 □Inp	_			413 140				Other (Specif	y)
Sun Co	f of Attending I after death. Director: After I in by the funer	ion	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	ig .	njury 28b. Time (Day Year) Injury	M 2	8c. Injury Work	rat ⟨? /es 2.∐1		28d. Describe h	iow injury	occurred .	
S	death ctor:	fica	3 ☐ Suicide 6 ☐ Could	not be One Blace of	Injury - At home, farm, s					28f. Location /3	Street and	d Number or Rura	l Route Number.
. <u>></u> .	after after Direct	Certification:	4 ☐ Homicide determ	building	etc. (Specify)		, 011100			City or Tox	n, State)		, restortante,
5/4	To the Hospital of Autending Physiciant. The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi And manner	est of my knowledge, dea s of examination and/or in stated.	th occurred nvestigation	at the tim in my op	e, date and pinion, deat	d place, a	and due to the o	cause(s) date and	and manner as si place, and due to	ated. the cause(s)
E	Tar Marie de la company de la	Me	29b. Signature and title of certifie	nich		290	. License					signed (Month,	
)			d. nu	Quil			Do	0619	59		\mathcal{C}	7/05/	05
	9+1		30. Name and ddr s of per	who completed cause	of death (Item 23a) (Type								
			Mahmoud Doski,		Lamberton 1	Orive	Silv	er Sp	ring	g, MD 20	0902		
	Sta Registr		31. Date filed (Month, Day, Year)	7 2005 32. R	strar's Signature	parti	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1 - State Registrer		aryland / Depa <i>Ce</i>	artment of F rtificate of		, ,	iene •g. ND N	5 21 122
Physicia /Medic		Decedent's Name (First, Middle, La Edna Lucille Mal	•				2. Date of Deat Month	Day	Year 8103 A M
Examin		4a. Facility Name (If not institution, give Atlantic General			4b. City, Town, o	or Location of Dea	ath	4c. County of	of Death
Funeral Director		5. Social Security Number 6. S		e (In yrs. last birthday) 81 Yrs.		If Under 24 Hr Hours Mir		Worce 1923	9. Birthplace (State or Foreign Country) MD
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
a-f she	ctor	MD Worceste	er	Ocean Pi	nes				1 □ Yes ¾☐X 0
with the	Dire	10e. Street and Number			10f. Zip Code		10	Og. Citizen of W	hat Country?
death v	Funeral Director	9 Brookside Road	12. Was Decedent I	Ever in U.S. 13.	21811 Was Decedent of F	Hispanic Origin? (Specify Yes or No-	USA 14. Bace	- American Indian,
and 21215-0036 be filed within 72 hours after death with the Maryland Atal Hygiene. And other than "natural", or items 23a or 28a-1 show event, the Medical Exeminer must be notified at event.	by	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No i	If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	Black	White, etc.
- c * 10	leted	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of we	orking	16b. Kind of Bus	siness/Industry
laryland 21215-0036 2 should be filed within 72 hours all and Mental Hygiene. Is marked other than "natural", or aumatic event, the Mudical Exami	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	cher	a)		Chur	ch
d be filed ental Hygic kad other	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	faiden Surname)
arylan should be and Mental s markad o umatic eva	2	James Leroy Klu 19a. Informant's Name/Relationship		10h Mailie	a Address (Street		Louise E		
≥ 5 € C →		Robert M. Mahlst					cean Pines		
Baltimore, Moemit. Pages 1 and Department of Health mportant: If tiem 27 any injury or other trong.		20a. Method of Disposition 1 □ Burial ★★★remation 3 □	Removal from State	20b. Place of Dispo			-		City or Town, State
t. Page rtmen rtant:		`4 ☐ Donation 5 ☐ Other (Specify	1)				09/2005 F		
Bal permi Depa Impo any ir		21. Signature of Funeral Service Licer	. Rayler	tu	Name and Addre	m Stree	urbage Fi t Berlin,	ineral I MD 218	lome 11
		20a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the leath. Do not ent	•	•			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chron	ic obstrua consequence of):	ctive	pulmo	NIM	diseo	se 5 yers
Examiner		Sequentially list conditions,	b	2 00/100400/100 01/.					
led led	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
68760, Worldington be executed gphysician and as the burial-transit	Exan	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
68760, ificate be expension as the buria	edical	(d						
B O E	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy	inf				
Records, P.O. Box 6 The law requires that the death certifi ute has been signed by the attending lage 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Monti	/
S, P es that gned b	by Pr	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contrib	oute to the cause of death?
cord: w require been sig							1 🗆 Yes	s 2□No 3	Probably 4 Unknown
	Completed						24a. Was an autopsy perform	ed? pri	ere autopsy findings available or to completion of cause of ath? Yes 2 No
	Be	25. Was case referred to medical examiner?	Hospital:		t all pos Oth	or.	ath (Check only one		
thy at d	n: To	27. Manner of Death	1 Inpatie		1 3L DOA	4 Nuising i	Home 5 Resider 28d. Describe how		
Vision of Attanding of Attandin	atlo	1 Natural 5 Pending 2 Accident investigation		Year) Injury		k? Yes 2 □No			
Division al or Attanding s after death. I Diractor: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	rry - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
Hospi 4 hou Funar	edical	Check only Z Medical Exam	imer: On the basis of	of my knowledge, death examination and/or inv	occurred at the tin	ne, date and place	e, and due to the cau	use(s) and mann	ner as stated. d due to the cause(s)
To the I within 2 To the I complet	Med	one) 29b. Signature and title of certifier	and manner sta	ted.	29c. License				Month, Day, Year)
⊢ s ⊢ ŏ) nell	1 p.	hysicie.	- 144	428.	2000	7/8/	05
2112	1	30. Name and address of person who o	completed cau e of de	eath (Item 23a) (Type, I	- If Go	7	0	1 2	. /
Stat		31. Date filed (Month, Day, Year)	32. Pagistra	r's Signature	HELL/1	inry	Orane	150	ren, M3
Registra	32	JUL 112	005	KA	4.00				

JET State of Maryland / Department of Health and Mental Hygiene

1 - State Unpend Item 23a&27 per me G845 Certificate of Beath

1 - Decedent's Name (First, Middle, Last) 05-04605 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jannae Miles Reg. No. 2 Amended Year Physician Jannae Miles July 8 2005 1:23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner 2602 Brinkley Rd #801 Fort Washington
If Under 1 Year If Under 24 Hrs. Prince Georges 8. Date of Birth (Month, Day, Sep. 2, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2 F Days Hours Min 19 Sep. 220-17-9395 Yrs 1985 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Show r then "natural", or items 23a or 28e-f shov the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Ft. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2602 Brinkley Rd., #801 20744 United State 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Maryland 21215-0036 1 Yes 2 No Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nail Technician Private 18. Mother's Name (First, Middle, Maiden Surname) th and Mental Hy 17. Father's Name (First, Middle, Last) Be Paul L. Miles, Sr. Janice Stafford 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heelth ar
Important: If item 27 Is
any injury or other treu Janice Miles - Mother 2305 Somers Ave., Burlington, NC 27215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Lee's Crematory 7/13/2005 Clinton, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 23a. Part 1, Enter the disease, or complications that cause I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or 1, art failure. List only one cause on each line. (lubar 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death Immediate aux (Final disease or condition resulting in death) **Physician** Diabetic Ketoacidosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-translt Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 see 2 No 24a. Was an page 2 s autopsy performed? Yes 2□ No : After this certification at the state of t Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE Hospital: 1 XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c, Injury at Work? 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident ë e 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by th 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel or 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 9

State

31. Date filed (Month, Day, Year)
JUL 1 5 2005

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 5:10 AM M Alfred Charles July Marmor 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7604 Quintana Court Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 30,1922 9. Birthplace (State or Foreign Country) New York **Funeral** Days 11XM 2□ F Director 081-18-5446 82 Nov. Usual Residence of Decedent iled within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Items 23a or 28a-f show The Medical Exercit et must be notified at 1 ☐ Yes 2X No **Funeral Director** Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7604 Quintana Court 20817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 10/0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No 1943− If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic event, I've Me Elementary/Secondary (0-12) College (1-4or 5+) Patent Attorney Law permit. Pages 1 and 2 should be filer Department of Health and Mental Hyg Important: If iem 27 is merked othe any injury or guber traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Marmor Agnes Stanko ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Marmor/Wife 7604 Quintana Court Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July Date 6. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 2005 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home wites 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 9 Months Immediate Cause (Final **Physician** Metastatic Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or). death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialnding physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) J_o 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033293 July 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frderick P. Smith, M.D. 5454 Wisconsin Ave. Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 3 Registrar's Signature Registrar JUL 0 8 2005

DHMH 17 Rev 1/2001

P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State / Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 5155 AM ICHARD MORT IMER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CLUM EN LY
If Under 1 Year | If Under 24 Hrs. |
Touche | Days | Hours | Min. | Prince Georges conter Prince George Hospital 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ M 2□F 579-30-6751 76 Director 1928 Wash. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 Greenvale Parkway or Iteme 23a 20784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 12 Yes 2 □ No 1946 -1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: naturel Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Regional Manager 12 Beverage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mantal Hitem 27 le marked othert: If item 27 le marked othert. Harry T. Mortimer, Sr. Stella Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Mortimer - Wife 6807 Greenvale Pkwy., Hyattsville, Maryland 20784 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 07-11-05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If any injury or once. Maryland Veterans Cem. Crownsville, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. Licenses 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstructive Pulmonony Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 🗆 No 3 Probably 4 □Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 27 No 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of centi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

TOA

31. Date filed (Month, Day, Year)

JUL 1 1 2005

IGNU

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATIN

9

3000 Hospital

055220

DRIVE

Cheverly

		•	For Stata Registrar	State of	Maryland / D	•	tment of He ficate of D			giene Reg. N	005	24126
	Physici		1. Decedent's Name (First, Middle, Myrtle	Last) Virgin	uia		Marcey		2. Date of De Month July 9,		Year	3. Time of Death 2:59 P M
	/Medic Examir		4a. Facility Name (If not institution, 7327 Branchwood To	_	ber)	- 1	b. City, Town, or Clinton	Location of Dea		4c. C	nce Georg	
	Funeral Director		5. Social Security Number 577–38–1578	6. Sex 1 □ M 2 X F	7. Age (In yrs. last birth 94 Yı		If Under 1 Year Months Days	If Under 24 Hi Hours Mi			Col	place (State or Foreign intry) Virginia
	Maryland febow	lor	Usuel Residence of Decedent 10a. State 10b. County Maryland Prince	ce George's	10c. City, Town Temple				-	,		10d. Inside City Limits 1 ☐ Yes 🏋No
	with the 3a or 28e-	Director	10e. Street and Number 8601 Temple Hills				10f. Zip Code 20748			10g. Citize	en of What Cou USA	untry?
920	s within 72 hours atter death with the Maryland liene. I then "natural", or Itams 23a or 28e-f ehow The Medical Examirar must be medified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Wildowed 4 Divorced	12. Was Dece	2x5x\n	If Y	s Decedent of His es, specify Cubar	spanic Origin? n, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		4. Race - Amer Black, White Specify:	
Maryland 21215-0036	within 72 ho ene. then "naturi ne Medical I	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		4or 5+)	Give kin life. DO	nt's Usual Occupa nd of work done d NOT use retired) nation Spec	uring most of w	orking		d of Business/li tment of	•
and 2	be filed ntal Hyg od othe event,	To Be Co	11th 17. Father's Name (First, Middle, L William Prescott	ast)				18. Mother's N	ame (First, Middle)		Sumame)	
	12 sh h and 7 le m treum	F	19a. Informant's Name/Relationsh Peggy Messina / Dar					nd Number or I	inton, Mar	er, City or		ip Code)
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition 11 ★ Burial 2 □ Cremation 14 □ Donation 5 □ Other (Sp		20b. Place of Cemetery Cedar H	ill C	enetery	07/1	Date 3/2005	Suit	ation - City or I land, Mai	ryland
Balt	permit. Departr Importe any inje		21. Signatur of Funeral Service L	1		616	O Oxon Hi	L1 Road C	eorge P. Ka xon Hill, I	Maryla		
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8760,	be executed cian and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b	or as a consequence of	1 0	nten	1 0	iseo (l		
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α.	quires that n signed b uld be deta	by	Part II. Dther significent condition	ns contributing to de	ath but not resulting in	the unde	erlying eause give	n in Part I.	23e. Did t	Δ		the cause of death?
Vital Records,		Completed	Super	elys c	Ce cus	<u>X</u>			24a. Was autor perfo		prior to co death?	opsy findings available ompletion of cause of 2 No
of	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2 ER/Outp	me of	3 DOA Othe	r. 4 🗆 Nursing	eath (Check only of Home 5 Residence 28d. Describe	dence 6	Other (Spec	Residence
Division	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After i completely filled in by the funera	Certification:	1 Accident 5 Pending investig: 3 Suicide 6 Could n 4 Homicide determine	ation ot be 28e. Place	of Injury - At home, farr g, etc. (Specify)	ury n, street	M 1 🗆 Y	res 2 □ No	28f. Location (Number or Rui	ral Route Number,
ם	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical Ce			best of my knowledge, sis of examination and er stated.							
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- 3	3		30. Name and address of person v PIOTR L. GRO 31. Date filed Month. Pay Year!	yho/completed cause	of death (Item 23a) (T	ype. Pri	y 16tro	Pike,	District	L ffe,	ights,	MD 20747
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			For Stete Registrer	State of Maryland		artment of H			ene g. No.2 N C	IE OLI	0.7
	Physici	an	1. Decedent's Name (First, Middle, L				**	2. Date of Death Month	Day Y	ear 9Time of D)dath
	/Medic	cal	JANET MARCIA 4a. Facility Name (If not institution, g	7.00		4b. City, Town, or	Location of Dea	July	01 20 4c. County of	3:20 Death) <u>A</u> M
	LAAIIII	ICI	Shady GROVE Adv	entest Hospital			ville			ntgomery	
	Funeral Director		5. Social Security Number 6. 058-82-1288	Sex 7. Age (In yrs. I. 1 ☐ M 2 🖾 F 4 3	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) - 1961	Birthplace (State or Country) Jamaica	Foreign
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	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show ha Medical Exactinat Loust Re codified at	io	MD 10b. County Mont	gomery	, Town or Lo Gai	thersbu	rg			10d. Inside City 1 Yes 2	
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21215-0036	ural, c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No				Black	
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and	d be fill antal H cad ott c avan	To Be	17. Father's Name (First, Middle, Las Ira George	•				me (First, Middle, M 7e O. Da			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is merked other then "natural", or itams 23a or 28a-1 show amy injury or other traumatic avent. The Medical Eracultust intell to coulfile of any injury or other traumatic avent. The Medical Eracultust intell to coulfile of any injury or other traumatic avent.	1	19a. Informant's Name/Relationship Kedeisha McKr	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or R	ural Route Number,	City or Town, Sta	ite, Zia Code)	78
	tand tealth		Kedeisha McKr			sition (Name of	DT # T(Oc. Location - Cit		
Baltimore,	Pages nent of lint: If its		1 Burial 2 Scremation 3 4 Donation 5 Other (Spec	☐Removal from State	ematery, crei	natory or other place Inrl Svc	· 1			dria, VA	
altii	Departme Importar any injur		21. Signatur of Funeral Service Lin		22	2. Name and Addres	s of Facility S	nowden F	uneral	Home, P	.A.
	80589		23a. Part1. Enter the disease, or co	V suous	/					le,MD 20	
	Physician /Medical Examiner	ner	shock, or heart failure List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	a. Tua to for as a consequence to for a	Mef- uence of):	as Papic	15 S41 114	lodykru		Interval Betwe	
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	gence of):						
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Vital	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	50/0.4	Othe	ar.	ath (Check only one			
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Divis	safor Attans s after death al Diractor; ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		me, farm, str	eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Numbe	ЭГ,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	Medical	29a. Certifying F (Check only one) Certifying F	Physician: To the best of my know eminer: On the basis of examinat and manner stated.	wledge, deat ion and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manne te and place, and	er as stated. due to the cause(s)	
	To the To the Complet	Σ	29b. Signature and title of certifier	Aller Ba		29c. License	271			Month, Day, Year)	
	U,		30. Name and address of person wh	o completed cause of death (Item	23a) (Type	ノ Print)	,0002	BLVDS	ruly	1,200	S
	6		DR AME	NOHIRATT	421	101 Rese	20wch	BLVDS	uite 33	o more	850
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	Physici		Decedent's Name (First, Middle, Last) JAMARI AMEIL OWENS				2. Date of Death Month	Day Year	3. Time of Death
}	/Medio Examin		4a. Facility Name (If not institution, give street and number)	13	4b. City, Town, o	Location of Death		4c. County of De	
			UPPER Chesapeake M	edica	lur B	rel Air		Harl	ard
	Funeral Director		5. Social Security Number 6. \$ex 7. Age 100 M 2□ F	(In yrs. last b	Yrs. Months Days	Hours Min.	8. Date of Birth July 8,	2005 Ma	irthplace (State or Foreign Country) Iryland
	pur &		Usual Residence of Decedent 10a. State 10b. County	10c City Tox	wn or Location				
	Maryla -f shor	tor	Maryland Harford	100. Oily, 104	Aberdeen				10d. Inside City Limits 1 Yes 2 □ No
	with the se or 28s	Director	10e. Street and Number 753 Battle Avenue		10f. Zip Code	21001	10	g. Citizen of What (country?
	death	nera	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race - An	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinations invited in 2016.	by Funeral	1 Mever Married 2 Married 1 1 Yes, 2 Model 3 Widowed 4 Divorced Year or Dates:	>	1 ☐ Yes 2 No	Specify:	nican, ec.)	Specify: B1	·
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of worki	ing 1	6b. Kind of Busines	s/Industry
72	withir liene. r then	omp	Elementary/Secondary (0-12) College (1-4or 5+)	Never Work				
Maryland 21215-0036	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Z	d Menid Inarke	To	Jasper Alexander Owens	10	h Marilian Addana (Garan	AVenna M			7.0.11
S	nd 2 st lith and 27 is r r traur	H	19a. Informant's Name/Relationship (Type, Print) AVenna M. Caldwell / mother		b. Mailing Address <i>(Street</i> : 753 Battle A				
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place o	of Disposition (Name of ery, crematory or other place	(8:	Date 2	0c. Location - City o	r Town, State
Baltimore,	t. Pag rtment rtant: I njury o		`4 ☐ Donation 5 ☐ Other (Specify)	St. J	ames United		1/05 Ha	avre de G	race, MD
Ba	Depa Impo any id		21. Signature of Funeral Service Licensee		22. Name and Addres	cott Fune: wis Stree	ral Home	P.A.	MD 21078
		7	23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	3.	not enter the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Pre-mat	vre	rupture of	membra	nes w	ithde	Onset and Death
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	p ti	iner	Sequentially list conditions, b. Due to (or as a cause. Enter Underlying	CuriSeddaffice	of).				
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P. O.	that the de ned by the a detached f	hysi	9 ☐ Unknown 9 ☐ Unknown						
Records,	sign sign	þ	Part II. Other significant conditions contributing to death but	not resulting	in the underlying cause give	en in Part I.	23e. Did toba	L	to the cause of death? Probably 4 Unknown
eco	has been ge 2 shoult	Completed					24a. Was an autopsy	prior to	autopsy findings available completion of cause of
E E	n: The ficate l						perform 1 ☐ Yes 2		s 2 No
Vital	Physician: r this certifica ral director, j	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Impatient	t 2 ERVO	utpatient 3 DOA Other	er: 4 \(\sum \) Nursing Ho		ce 6 □Other (Sp	ecity)
on o	Jing Afte fune	tion; T	27. Manner of Death 1. Natural 5 Pending (Month, Day) 2 Accident investigation	28b.	Time of 28c. Injury Work	Access to the second second	28d. Describe how		33.17)
Division of	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 □ Suicide 6 □ Could not be	y - At home, f (Specify)	arm, street, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)	examination a	e, death occurred at the time of time of time of the time of the time of the time of t	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated.
	To the within To the comple	Me	29b. Signature and title of certifier	70.	29c. License	number	290	d. Date signed (Mor	ith, Day, Year)
}			· Claudea K. Jus	faul	CNM W5	56777		7/8/05	-
	C		30. Name and address of person who completed cause of the 500 (Land).	th (Item 23a)	(Type, Print) Bol	Ris V	nd 21		
	Sta Registr		31. Date filed (North, Day, Year) 32. Registrar	's Signature			1		
	1.091011		- con hims	- 17					

			For State Registrar	State of Marylan	d / Dep	artmen		•	/giene	egible.	
	Physici	an	Negistrar Necedent's Name (First, Middle, Last AMARI JONE			rimodic	o o Deam	2. Date of D Month	Reg. No. eath Day	X025	3.4 malor Death 9
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	street and number) ake Medical	LTY last birthday, Yrs.	4b. City, If Under Months			1	ounty of Death Out Co	ce (State or Foreign
	D	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Hari		y, Town or L		Aberdeer		100		d. Inside City Limits 1X Yes 2 □ No
	th with the 23s or 2 unit be a	ai Dire	10e. Street and Number 753 Battle Ave	enue		10f. Zip	21001		-	n of What Countr USA	y?
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exafra within the Indillied at	by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	.S. 13.	Was Deced If Yes, spec	ent of Hispanic Origin ify Cuban, Mexican, P X No Specify:	? (Specify Yes or N Juerto Rican, etc.)	ŀ	Race - Americal Black, White, et pecify: Blac	c.
21215-0036	l within 72 ho liene. r than "natur r in Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	e kind of wor DO NOT us	I Occupation k done during most of e retired) Worked	working	16b. Kind	of Business/Indu	stry
Maryland 2	buld be filed Mental Hygis arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Jasper Alexander () Wens				Name (First, Middle) a Marie (,	
	1 and 2 should Health and Men Iom 27 is marke	ľ	19a. Informant's Name/Relationship (T AVenna M. Caldwell				(Street and Number of e Avenue,				
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1	Talliovat from State C+	Place of Displacemetery, creations James	osition (Name of the Marketon of the State o		Date 7/11/05		ation - City or Tow e de Gra	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	cott	2	2. Name and L1 55	Address of Facility Sa Scott F 2 Lewis St	uneral Ho	me, P	.A. Grace.	MD 21078
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)		Uptur		e of dying, such as cal				Approximate nterval Between Onset and Death
760,	te be executed ysician and te burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq							
O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	□Ectopic pro			23	d. Date of delivery Month E	/ Vay Year
Δ.	quires that in signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the	underlying ca	ause given in Part I.		tobacco use	contribute to the	cause of death?
il Records,	S S	Completed						24a. Wa aut per 1 □ Yes	s an opsy formed? 200 No	24b. Were autops prior to compleath? 1 Yes 2	sy findings available pletion of cause of
Vital	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital: 🗸				Death (Check only	one)		
of	ulng Phy I. After this funeral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury		A Other: 4 Nursi	ng Home 5 Res			
Division	al or Attending s after death. il Director: After id in by the fune	Sertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, s	treet, factory		28f. Location	(Street and i	Number or Rural	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying Phyone 2 Medical Example 2	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, dea	th occurred nvestigation,	at the time, date and p in my opinion, death	place, and due to the occurred at the time	e cause(s) ar	nd manner as sta lace, and due to t	ted. he cause(s)
	To the within to the comp	×	29b. Signature and title of certifier	1. 2. Sant	TALAN	29c	License number		29d. Date	signed (Month, D	ay, Year)
•	0		30. Name and address of person who of	ompleted cause of death (Iter	n 23a) (Type	p. Printy	Bis	Nd 210	014	8100	
	St Regist		31. Date filed (Yorth, Day, Year)	32. Registrar's Signa	ature	,	no c	The state of the s			

			1 - For Stete Registrer Amend #19a . Per	State of Maryland		rtment o			-	_	005	21 120
	Physici	an	Hegister Attel 12 # 1 24 • Fel Decedent's Name (First, Middle, Last) Sharon Yvont			incate t	or Dea		2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Tow	m, or Locat	tion of Death	06-30		5 County of Deat	5:50 A.M
	CAGIIIII	E1	4413 Rena Road #104			Suit		- 11			ince Ge	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	**	If Under 1 Ye	ear If Ur	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	M 223F 47	Yrs.				10-14-	1957	F1o	rída
	yland Jow		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Mar ta-f st	ctor	Maryland Prince Ge	eorges Su:	it1and							1X Yes 2 No
	with th	Director	10e. Street and Number 4413 Rena Road #104			10f. Zip Coo	_{de} 20746			10g. Citiz	en of What Co	1
	eath v	Funeral		2. Was Decedent Ever in U.S	S 13 V			c Origin? (Sp	acify Yas or No	n 1	U.S.A	
9	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28a-f ehow fre Modfed Excritter must be notified at	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No					ecify Yes or No Rican, etc.)	1	Black, White	e, etc.
93	urel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2 X		эспу:			Specify: B1a	
7	n 72 h	lete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	lent's Usual Ockind of work do NOT use re	one during	most of work	ing		nd of Business/ er Reed	•
212	d with	Completed	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		ied Nu	,	Assis	tant	è	cal Cen	2
g	al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. N	dother's Name	e (First, Middle			
<u>ya</u>	d Men d Men narka natic	2	Granville Cambridg					aretha				
altimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Is marked other than "neturel", or Items 23e or 28a-f show other traumatic event, If a Modical Exempter traumatic event		19a. Informant's Name/Relationship (Type Michael A. Profitt	Husband	4413 Suit1	Rena Ro Rena Ro and, Ma	reet and Ni Oad # . orv1a:	umber or Hur 104 nd 20	ai Route Numb 746	er, City or	Town, State, Z	(ip Code)
e,	of Hea item		20a. Method of Disposition	20b. Pl		sition (Name o			Date	20c. Loc	cation - City or	Town, State
Ē	Page ment cent: If ent: If ury or	- 73	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	HOVAL HOILI State	sapeak	e Crema	atory			Be1t	sville	, Maryland
Balt	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trai		21. Signature of Funeral Service Licenses	Baconce	3/2/34	Name and Ad 47 14th	ddress of F n Stre	eet, N	. Bacon .W. Was	Fune	eral Ho D.C. 20	me, Inc. 010
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ente	er the mode of	dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		myor	ardial	in	farcti	01			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	2017	alte	erial	dide	and		Years
	الخنور	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		7						
	scuted nd transit	Examiner	that initiated events									
8760,	icate be executed physician and s the burial-transit	af Ex	resulting in death) Last	Due to (or as a consequ	ience of):							
687	ficate physics the	edicat	d.									
	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnar		Ectopic pregna				2	3d. Date of deli	very
Division of Vital Records, P.O. Box	the att	by Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at time of de		Other (specif)					Month	Day Year
۵.	that the dendered by the a	y Ph	Part II. Dther significant conditions cont	nbuting to death but not resu	Ilting in the un	nderlying cause	given in P	Part I.	23e. Did t	tobacco us	se contribute to	the cause of death?
rds	w requires that been signed I should be det	ed b	Renal failure	on remode	alysi	5 hy	parte	2015141	1/ 1/2	Yes 2□	No 3□Pr	obably 4 Unknown
ecc	law re las be	Completed	diabetes m	ellitus					24a. Was	an	24b. Were au	topsy findings available
<u> </u>	The								1 Tes	ormed? 2 X No	death?	2□ No
<u> </u>	sicier certif irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 E	5D/O-45-45-4	t 3 DOA			Check only		□Other (Spec	
0	g Phy er this eral d	n; To	27. Manner of Death		28b. Time of Injury		Injury at Work?		28d. Describe			erty)
sior	endin eath. or: Afi	catlo	1 X Natural 5 Pending 2 Accident investigation	(Moral, Day 1 ear)	ilijary		1 Yes	2 🗆 No				
<u> </u>	after d after d I Direct d in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, off	ice		28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 1 Certifying Physi 2 Medical Exemin	cian: To the best of my knov er: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the	ne time, dat ny opinion,	te and place, , death occurr	and due to the red at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				ense numb			29d. Date	signed (Month	
)	(Randheu					00616	1		715/0.	5
2	(2)		30. Name and address of person who con 913 1 PISCALWAY	Road, ste	, 750	Print) Ra	vinde	, My	D	~07	35	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 7 2005	Registrar's Signat	See.	R)						

			For	State of Ma	aryland		artment of H		Mental Hy	giene		
			1 = State Registrar			Ce	rtificate of l	Death		Reg. No.	2000	21.12
	Physici	an	1. Decedent's Name (First, Middle,	BUL	143	1	Drac	_	2. Date of Do Month	Day	y Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,				4b. City, Town, or			3-d	2005 County of Death	16=05 M
I	Examin	er	HAZEOND MY	-		TAL		_	LACE		tA2 Fo	
	Funeral			6. Sex 7. Ag	ge (In yrs. la		If Under 1 Year	If Under 24 Hr	S. 9 Date of Bi	rth	Q Rist	nplace (State or Foreign
	Director		180-22-2822	1½M 2□F	75	Yrs.	Months Days	Hours Mir	8/3/192	29 (64/)	Penr	intry) isylvania
	pue M		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Li	ocation					10d. Inside City Limits
	daryli f sho	5	PA York C	ounty		over						Y⊠Yes 2□No
	28a-	Director	10e. Street and Number	<u> </u>	Tidin		10f. Zip Code			10g. Cit	izen of What Co	
	h with	IO IE	238 Baer Avenue				17331			l	Jnited Sta	tes
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or N	0-	14. Race - Amer Black, White	
9	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-1 show a Modical Examirer must be multised an	y Fu	1 Never Married 2 Marrie	lf Yes, Give	No		1 ☐ Yes 2 🛣 No	Specify:	no modifi, sto.)			ite
21215-003	tural',	ed by	3 Widowed 4 Divorced	Year or Dates:	1953	16a Door	dent's Usual Occup	ation		10h K	ind of Business/l	
5	in 72 n "na nzalic	Completed	(Specify only highest	grade completed)	5.)	(Give	kind of work done of DO NOT use retired	during most of w	orking	10D. K	ind or business/i	ridustry
212	d with giene.	E O	Elementary/Secondary (0-12)	College (1-4or	5+)	Owner	r/Operator			Sub	Shop / C	atering
힏	al Hyg	Be C	17. Father's Name (First, Middle, L.	ast)				18. Mother's Na	ame (First, Middle	, Maiden	Sumame)	
Maryland	should be tind Mental I	To	Gerald Pfaff					Mary	Anthony			8.7.1
Jai	2 sh and is m		19a. Informant's Name/Relationshi				ng Address (Street			per, City o	or Town, State, Z	ip Code)
	1 and 1ealth em 27 ther t		Ellie M. Pfaff - W 20a. Method of Disposition	1fe	20b Pla		er Avenue,	Hanover,	PA 17331	200 14	ocation - City or	Four State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, Ite Medical Examinet must be notified at ance.		1 ∆ Burial 2 ☐ Cremation		ce	metery, cre	matory or other plac vet Cemeter		7, 2005		•	•
를	artme ortani injury		 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service □ 		Piodi							
Ba	Depar Impor any ir	7 1	121.6		CC (0354 Ke	2. Name and Addrese Enworthy Fur anover. PA 1	neral Home	e, Inc., 26	59 Fre	ederick St	reet,
П			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	d the death.				ac or respiratory	arrest,		Approximate Interval Between
	Pnysician	١.	Immediate Cause (Final disease or condition		A S C	JD.						Onset and Death
	/Medical		resulting in death)	Due to (or as								
	Examiner	L	Sequentially list conditions,	b. Due to (or as								
	bed nsit	nlne	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseque	erice or):						
	avecur n and al-trai	xan	that initiated events resulting in death) Last	C. Due to (or as	s a conseque	ence of):						
8760,	icate be executed physician and s the buriat-transit	dical Examiner		d								
9	rtificat ng phy as th	a)	IS SENALS.								-	
õ	th ce tendii or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			☐Ectopic pregnancy				23d. Date of deli	very Day Year
P.O. Box	ires that the death certif signed by the attending d be detached for use a:	Physiclan/M	1 Yes 2 No	4☐Pregnant a 9☐Unknown	at time of de	ath 5	Other (specify)				MORITI	Day rear
	that the ed by detac	Ph	Part II. Other significant condition	ns contributing to death I	but not resu	Iting in the	ınderivina cause aiv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	uires I sign Id be	d by		STIVE H					1 🗆	Yes 2	XNo 3 □ Pro	obabiy 4 Unknown
00	w require b been signature should b	lete							24a. Wa	s an	24b. Were au	topsy findings available
æ	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed							auto perf 1 🗌 Yes	opsy ormed? 2. No	prior to d	completion of cause of 2000
Division of Vital Records,	ian: intifica ctor, p	Be C	25. Was case referred to medical					26. Place of D	eath (Check only		1 1 1 1 0 3	2410
<u>></u>	hysic his ce	70	examiner?	Hospital: 1 ☐ Inpati	ent 2	R/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing	Home 5 ☐ Res	idence	6 □Other (Spec	cify)
n	ing P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending		ury ay Year)	28b. Time o Injury	Wor		28d. Describe	how inju	ry occurred	
Sic	ttend death stor: /	icat	2 Accident investigation investigation and accident accident and accident ac	ot be	iun, Athor	ma farm at		Yes 2 □ No	29f Location	(Ctroot or	nd Number or Pu	ral Route Number,
<u>≥</u>	after Direction by	Certification:	4 Homicide determine		tc. (Specify,		reet, factory, office		City or To			rar noble Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying	g Physician: To the best	t of my know	vledge, dea	th occurred at the tir	ne, date and plac	ce, and due to the	cause(s) and manner as	stated.
	ns Ho n 24 t ne Fu oletely	edical	(Check only 2 Medical E	Examiner: On the basis of and manner s	of examinati	on and/or i	nvestigation, in my o	pinion, death oc	curred at the time	, date and	d place, and due	to the cause(s)
		Σ	29b. Signature and title of certifier	Λ Λ			29c. Licens	e number			te signed (Mont)	
•	WIL		Marush	- in		10	0 2	21809		7-	14 3,	2005
	15		30. Name and address of person v						-		,	
	0.		31. Date filed (Month, Day, Year)	32 Raniell	trar's Sinnat	3 3 6 ure	YORK	ND	IIMO	ر، ر	JM M	021093
	Sta Regist		.1111.0	7 2005 32. Regis		K	had.					
DI	IMH 17 Rev 1/2	2001	302 0		-	1	7					

Physici	an	RegistrerEND TTEM #7 1. Decedent's Name (First, Middle, Last,	8&12 PER INF G84	Gertificate of E 9/19/05	JH	2. Date of Dea	th		Time of Death
/Medic	al	MELVIN FLOYD PA				July			7:50 A.A
Examin		4a. Facility Name (If not institution, give PRINCE GEORGE S HO		4b. City, Town, or CHEVERL			4c. County	of Death GEORG	E'S
uneral		5. Social Security Number 6. Sec	7. Age (In yrs. last birti		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 2-22	Vear 1929	9. Birthplace	(State or Forei
irector		579-52-8533 Usual Residence of Decedent	 	rrs.	Hours Min.	2-22	-1922	MITCHE.	LLVILLE
a-f show lifted at	ctor	10a. State 10b. County Md PRINCE GE	ORGE's CAPITO	OL HEIGHTS					nside City Limi
Nor 28	Funeral Director	10e. Street and Number		10f. Zip Code			IOg. Citizen of W	Vhat Country? STATE	c
ns 23	erai	710 IONA TERRACE	12. Was Decedent Ever in U.S.	20743	spanic Origin? (Sp	ecify Yes or No-		e - American Ir	
od other than "natural", or liems 23a or 28a-f show event, the Madical Examinat must be notified at	Ď	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)		k, White, etc. BLACK	
natur	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	tion uring most of work	ing	16b. Kind of Bu	siness/Industr	у
than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	POLICE OF			LAW I	ENFORCE	MENT
other than vent, the Me	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumam	9)	
marked c	To B	LEWIS PARKER SR.			MARIAN	OWENS			
4 40 2		19a. Informant's Name/Relationship (T) MARY YOUNG PARKER		Mailing Address (Street a					
item 27 l		20a. Method of Disposition	20b. Place of	O IONA TERRA Disposition (Name of		OL HEIGI Date	20c. Location -		
		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cemeter	y, crematory or other place	9)				Stato
Important: I any injury o once.		21. Signatur Funeral Service Cons		GTON NATIONA 22. Name and Addres		- 05 <u>1</u>	ARLINGTO		d 2074
any in		23a. Part1. Enter the disease, or compishock, or heart failure. List only o	1100	CUFFEE FUNE	RAL SERV	ICES 68	15 WILBU		
ledical aminer parial-transit	cai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of HYPERTENSION Due to (or as a consequence of CERBROVASCULAR Due to (or as a consequence of CERBROVASCULAR)	ACCIDENT					
led by the attending physicien and detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	5 Other (specify)			Mor		
been signed should be de	by	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause give	n in Part I.		bacco use contr es 2□No	3 ☐ Probably	
ate has page 2	Completed					24a. Was a autop perfor	med? p	Were autopsy to comple leath?	tion of cause of
	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ∰ Inpatient 2 ☐ ER/Ou	othe	26. Place of Deal			(Cif-)	
deam ctor: After this y the funeral di	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	Fime of 28c. Injury Work	at	ome 5 Resid 28d. Describe h			
s arrer dear al Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Ro	ute Number,
within 24 hours after of the funeral Direct completely filled in by	edical (29a. Certifier 1 ✓ Certifying Phy (Check only one)	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the tim d/or investigation, in my op	e, date and place, inion, death occur	and due to the or	ause(s) and ma date and place, a	nner as stated and due to the	cause(s)
To the complet	Me	29b. Signature and title of certifier	•	29c. License			29d. Date signed		Year)
AC.		I some			54140		07/08	8105	
		30 Name and address of person who o	ompleted cause of death (Item 23a)	(Type, Print)		1	1		

			1 - For State Registrar	State of Maryland / E	Department of Certificate o			iene _{ag. No.} 2005	26133
			Decedent's Name (First, Middle, Last				2. Date of Deat	h	3. Time of Death
	Physici /Medid		Margaret Ruth	Phillips			July	10 2005	2:50 A M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town	, or Location of Death	1	4c. County of Dea	
			Washington Adventi			ma Park		Montgome	ery
	Funeral Director		5/7-38-93/7	3. O. O.	thday) If Under 1 Yes Months Day		8. Date of Birth (Month, Day, Jan. 19	,1926 Ter	thplace (State or Foreign ountry) INESSEE
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	f sho	٥	MD Prince Ge	orgo's La	nham				1 XYes 2 No
	28a	Director	10e. Street and Number	20160 5	10f. Zip Code	•	10	0g. Citizen of What C	ountry?
	3a of	ā	8646 Brae Brooke	Drive	20	706		USA	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puert	pecify Yes or No-	14. Race - Am	
21215-0036	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show The Microal Examinar must be motified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 🏋 N		nican, etc.;	Black, Whi	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occ (Give kind of work do	cupation	kina	16b. Kind of Business	/Industry
2	C *	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use ret	ired)	9	W G G	
	illed withir Hygiene. other then		12	A	nalyst	10 14-15-4-11-	(==== 14144= 1	U.S. Govt	•
Maryland	€ 2 5 0	To Be	17. Father's Name (First, Middle, Last) Murray S. Taylor				ne (First, Middle, M Ann Ha11	Maiden Sumame)	-
lan	and and is m		19a. Informant's Name/Relationship (T)		. Mailing Address (Stre				Zip Code)
	1 and 2 Health Iem 27 i		Mary Ann Phillips		46 Brae Br	ooke Dr.	Lanham,		
0	ges 1 ar it of Hea if item or other		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemeter	Disposition (Name of ry, crematory or other p			20c. Location - City or	
Baltimore,	it. Pa rtmen rtent: njury	1	* 4 □ Donation 5 □ Other (Specify)		of Heaven C		The second secon	ilver Spri	lng, MD.
Ва	permit. Pages 1 Department of F importent: if ite any injury or ot		21. Signature of Funeral Service Licen	Powell	22. Name and Add	De	eall Fune Bowie,		.5
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. Do not cause on each line.	not enter the mode of o	tying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARDIAC	ARRH	YTHM	1 A		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	A	1/000	10011		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	RESPIRY	77089	-HIL	URE	
	cuted id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	URINARY	TRAC	TINF	ECT	102	
0,	e exectan an an urial-tr	Exa	resulting in death) Last	Due to (or as a consequence	of):				
68760,	icate be executed physiclan and s the burial-transit	dicai	(MICTASTA	TIC B	REASI	CAN	CER	
Box 6	eath certifi attending I for use as	an/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregna	ncv		23d. Date of de	,
.O.	at the dea by the att	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)			Month	Day Year
ds, P	es the igned be de	by	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause	given in Part I.		acco use contribute t	o the cause of death?
Record	sw requires been so should	Completed					24a. Was ar	24b. Were a	utopsy findings available
Re	The lav	шо					autops perform	ned? death?	completion of cause of
Vital	sician: T certificat rector, pa	O	25. Was case referred to medical			26. Place of Dea	th (Check only one		22.10
of V	d is	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA	Other: 4 Nursing H	ome 5 Reside	nce 6 Other (Spe	ocify)
	ing After une		27. Manner → Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation			njury at Vork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, offic	Ce Ce	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	urs Bra		29a. Cartifier 1 Certifying Phy	sician: To the best of my knowledge	death occurred at the	time date and place	and due to the ca	auco(s) and manous a	c stated
	T 4 F W	edicai	one)	ner: On the basis of examination an and manner stated.	d/or investigation, in m	y opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier	W. do		ense number	25	9d. Date signed (Mon.	
•	(5)		Chandras		7	52855		July 10,	2005
	De		30. Name and address of person who c Chandra S. Korapa		^(Type, Print) 3 Hanover F	kwy. Gree	enbelt, M	D. 20770	
14	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	्या	10F + + 7001 15	due It Speck					

Verona P. 05-04727 crn	Pinn	0C	mend item#10c po	e Type or Pri	nt in larylar	Black Ir 05 TT w./,Dep	ndelib artme	entoth	Ensure A	VII Copie Mental H	s Are	e Legibl	e.	
	ysiciar		For Unpend Item State Registrer 1. Decedent's Name (First, Middle, I VERONA P. PIN	.ast)	- ше	GO41 Ce	ertifica	ate of	Death	2. Date of E Month JULY			15 24 3. Time of 7:05	
//	Medica amine	L	4a. Facility Name (If not institution, g Prince George's	rive street and number		er	4b. Ci	-	r Location of Death			c. County of		A M
Fur Dire	ctor		5. Social Security Number 6 078-86-0208 Usual Residence of Decedent	4 C 14 O K	43	. last birthday Yrs.	Month	der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8. Date of E	196		Birthplace (State Country) amaica	or Foreign
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow	notified at	0000	MD 10b. County Prince (George	Caj	pitol I	leigh	its Zip Code			100.0	Citizen of Wha		City Limits s 2 ☐ No
death with	inermatite natified	ielai Di	6506 Ronald Road	12. Was Deceden		J.S. 13	20 . Was Dec	743 cedent of H	lispanic Origin? (S	pecify Yes or N	Jan	naica	American Indian,	
.0036 hours after tural', or Ita	at Examina	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	₹ No	100 P	1 🗆 Yes	2 🔼 No	an, Mexican, Puert Specify:	o Rican, etc.)		Specify:		
21215. ed within 72 /giene. er then "na"	it, the Medical	combien	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	Medic	e kind of DO NOT		ation during most of wor d)	rking	Mar	Kind of Busin nor Car sing F	re	
Iryland should be fill ad Mental Hy marked oth	matic even	ממ	 Father's Name (First, Middle, La unknown Informant's Name/Relationship 		-	19b Mai	ling Addre	es (Street	18. Mother's Nar Hazel S and Number or Ru	mith		,	te Zin Code)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Dependentent of Health and Mental Hygiene.	or other trau		Cosley A. Pinnocl	k/Son	1	6506 Place of Disp	Rona Rosition (A	.1d Rd	. Capito	1 Heigh	ıts,	MD 207	743 y or Town, State	
Baltim permit. Pag Depertment importent:	any injury o		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic	cify)	Cec		22. Name	and Addres	ss of Facility Ce)/2005 edar Hill	Fune			
Physi			23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	implications that cause by one cause on each Cardiac	line.	th. Do not er	nter the m		vania Ave. ng, such as cardiad			20/46	Approxima Interval Be Onset and	etween
/Med Exam	iner	0	resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as										
60, be executed	burial-transit	4	cause. Erner Underlying Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as	s a conse	quence of):	-							
Vision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be reason: After this certificate has been signed by the ettending physicial corrections.	letached for use as the buri	al vincolo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fet	al death 3	□Ectopic	pregnancy				23d. Date o	f delivery Day	Year
P.O.			in the past 12 months? 1 Yes 2 No 9 Unknown	9□ Unknown					en in Part I.	23e. Dio	tobacco	use contribu	te to the cause of	death?
cords w requires been sign	should									1 [24a. Wa	Yes :		Probably 4 =	
Division of Vital Records, to Attending Physician: The law requires to effect death.	director, page 2		25. Was case referred to medical						26. Place of Dea	aut per 1 Yes	opsy formed? 2 \(\sqrt{N}	prio	r to completion of M? Yes 2□ No	cause of
of V Physic	direct direct		examiner? 1 ∆ Yes 2 □ No	Hospital: 1 Inpat		ER/Outpatre	ent 3 🗆	DOA Oth	or-	lome 5 Re		6 □Other (Specify)	
ision C ttending P death. ctor: After t	funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	h.		28b. Time Injury	М		yat k? Yes 2 □ No	28d. Describe	e how in	ury occurred		
Division To the Hospital or Attendmithin 24 hours eiter death	filled in by		4 Homicide determine	building, e	tc. (Speci	ity)				City or T	own, Sta	te)	or Aural Aoute Nur	nber,
To the Hos within 24 hc	completely filled in		one 2)() Medical Ex	Physicien: To the bes eminer: On the basis and manner s	of examin	owledge, dea ation and/or i	nvestigati	on, in my of	pinion, death occu	red at the time	e, date ar	nd place, and	due to the cause(s)
P T With	8		/ Cale	my)					o.C.M.E.			Ly 14,	1005 Aonth, Day, Year)	
HINI			30. Name and oddres of person wh	o completed cause of	P	111 Pe		Street	, Baltim	ore, Ma	aryla	and 212	201	
Re	State gistrar	-	31. Date filed (Month, Day, Year) JUL 1 6 2005	32. Regist	ar s Sign	Consell								

			For State Registrar	State of N	Marylan	•	artment rtificate			ind Me		iene eg. No. 2	,000	21 100
	Physici		1. Decedent's Name (First, Middle George Emmet						-	2	2. Date of Deal Month July	h Dav	005	3. Time of Death 3
	/Medio Examin		4a. Facility Name (If not institution		er)		4b. City, To	wn, or	Location or	f Death	July		unty of Death	10:47
	Exami		Civista M	ledical Cent	er		La	P1a	ta			Ch	arles	
	Funeral Director		5. Social Security Number 215-36-3517	6. Sex 7 1 M 2 ☐ F	Age (In yrs. 85	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day) une 26	^{Year)} 1920	9. Birthi Cou Mary	place (State or Foreign ntry) / land
	land	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary -f she	호	Maryland Char	·les		Wald	orf							1 ☐ Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip C	ode			1	0g. Citizen	of What Cou	ntry?
	23a c		2343 Tawny Dri	ve					2060)1			US	
336	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show the Modeal Exc. nither must be notified at	by Funeral	11. Marital Status 1 □ Never Married a Mar 3 □ Widowed 4 □ Divorced	If Yes Give	is? ⊡ No	ł	Was Deceder If Yes, specify 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Race - Ameri Black, White, ecify:	
21215-0036	72 hours "natural", ciral Ex.	Completed		it's Education		16a. Dece	dent's Usual	Occupa	tion	of working		16b. Kind	of Business/In	dustry
21	d within 72 ho piene. r than "natur ne wedical	nple	Elementary/Secondary (0-12)	st grade completed) College (1-4c	or 5+)	life.	kind of work DO NOT use	retired,)	or working	'			
12	7 7 2		12	(12-0)		Rural	Mail	Car		d= N=				Service
Maryland	ed la	To Be	17. Father's Name (First, Middle, Oliver Fairfax	Pickeral					Lo	rena	Picker	al		
	47 P		19a. Informant's Name/Relations Odra M. Pickera			7					Route Number rf, MD	-		o Code)
Baltimore,	of of		20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (S	3 ☐Removal from Sta	0	Place of Dispo	sition (Name matory or other	of er place	9)	Da		20c. Locati	ion - City or To	own, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee M012	246	H P	Name and Untt F	Addres UNE OX	ral F	ome Wald	orf, MD	2060)4	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	sed the deat line.	1	er the mode					est,		Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	resulting in death) Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Pene	as a conseq as a conseq	uence of): uence of):	losen	LL	net	7521	245E			x years.
8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last	Due to (or Sew (2		unagen of):					NENT	ę		L MONTH.
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta tat time of d	ıldeath 3[Ectopic preg					23d	. Date of deliv Month	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to deat		ulting in the u	nderlying cau	ise give	n in Part I.		23e. Did to	1		he cause of death?
Records,	The law reate has bee page 2 sho	Completed									24a. Was a autops perform		prior to co death?	opsy findings available impletion of cause of
Vital	itcian: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?						26. Place	of Death	Check only or			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 5 (No	Hospital:		ER/Outpatie		1	4 🗆 (40)		e 5 🗆 Reside			(y)
		atlon:	27. Manner of Death 1 Natural 5 Pendii 2 Accident invest	28a. Date of I ng (Month, igation	njury Day Year)	28b. Time o Injury	f 280	injury Work	at :? Yes 2⊡t		d. Describe h	ow injury o	ccurred	
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Place of	Injury - At h, , etc. (Specif	ome, farm, st	reet, factory,	office		28	Rf. Location (Si City or Town	reet and N n, State)	umber or Run	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 1 Certifyii (Check only one) 1 Medicel	ng Physicien: To the be Examiner: On the basi and manner	s of examina	owledge, deat ation and/or in	h occurred at vestigation, in	the tim	e, date and pinion, deat	d place, ar	d due to the c d at the time, d	ause(s) and ato and pla	d manner as s ice, and due t	stated. o the cause(s)
)	To t withi To tl	M	29b. Signature and title of certifie	a Cal	m			License	number 629		2	9d. Date si	igned (Month,	Day, Year)
(BILEI		30. Name and address of pelson George Wathe					10	3 Wal	dorf	, MD 20	603	., 0-	
J	Sta Regist		31. Date filed (Month, Day, Year JUL (ature /								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Elizabeth JULY 2005 11:00 A Mae Perry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 15, 1919 Birthplace (State or Foreign Country)
 Va **Funeral** 1□M 2**X**F Months Days Hours Yrs. Director 577-18-3316 86 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28e-f show 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show traumatic event, its Medical Exaction in market by trailing at Completed by Funeral Director 1 ☐ Yes 2 ₩ No WV Morgan Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25434 P.O. Box 155 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 No Specify: Specify: White It Yes, Give Year or Dates: 3 Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Administrative Assistant</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Percy L. Wynkoop Bessie Milstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is i ury or other traus (Son) 800 Gamble Rd. Great Cacaon, WV 25422 James R. Perry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. 7/15/05 Paw Paw, WV Island Hill Cemetery 21. Signature of Funeral Service Liceuse 22. Name and Address of Facility McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 ames 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hemorr has days brown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner To the Hospital or Attending Physician: The law requires that the death certiticate be executed burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 TProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Obstruc 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Memorial

32. Registrar's Signature

awantemann, M. 1,

SEMAAN,

2 2 2005

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 9, 2005 Juan Jose Ouinionez 11:19 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, March 16, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 11☑M 2□F 215-31-4343 50 Director 1955 Guatemala Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at Director Maryland Yes 2 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1524 Electric Avenue 20785 Guatemala death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2□No Specify: Guatemalan þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth-any injury or other traumatic evant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Everildo Tobar Ouinionez Nicolasa Aguilar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ima Y. Quinionez (Wife) 1524 Electric Avenue, Hyattsville MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State General Cemetery 7/17/2005 Guatemala City, Guatemal * 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRendon/Hale Funeral Home 21. Signature of Funeral Service License 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCANDIAL **Physician** /Medical Examiner TICEMI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that the death certificate be executed OF THE LIVER Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ should be 3 ☐ Probably 4 ☐ ₩nknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 1 No Division of Vital 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attanding Patter death.

I Diractor: After it After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Defining rivisions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cent 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DONALD GEORGE 3061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8:55 P RESNICK JULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE 8. Date of Birth (Month, Day, NOV 5, Birthplace (State or Foreign Country)
 OKLAHOMA 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1√2 M 2□ F 91 Director 102-10-1609 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ahow ral, or items 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 MONTROSE ROAD 20852 UNITED STATES death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: Specify 3

Widowed 4 □ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) ges 1 and 2 should be filed with It of Health and Mental Hygiene. If Item 27 is marked other than LAWYER COMMUNICATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BARNEY RESNICK SARAH traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES RESNICK, SON 7543 FALLON DRIVE, PENNSAUKEN, NJ 08109 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
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any injury or ott 1 Byriai 2 Cremation 3 X Removal from State NATIONAL CREMATORY JULY 14, 2005 FALLS CHURCH, VA d Donation 5 Other (Specify 21. Signature of Funeral Service L icansaa DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD STAL Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure). List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prebable Altheimeir **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tarly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown à law requires that 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has The page 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 28710 this 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 1/2 D 22528 5, 2005 de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 mentrese Road 6121 Bilks

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar 31. Date filed (Month, Cay,

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

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To the within To the complex	Me	29b. Signature and title of	of certifier	\ /	4		29c. Licens	e number		29d. D	ate signed (Mo.	nth, Day, Year)
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Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit production.	Medical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Units and the cause of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II Dther significant conditions control warminer? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Medical Exeminer one) 29a. Certifier (Check only one) 1 Certifying Physicial (Check only one) 1 Certifying P	Due to (or as a conseque Due to (or as a conseque If yes, outcome of pregnant 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown buting to death but not result 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify) ian: To the best of my knowless of examinatic	ence of): ance of):	26. Place of Death ther: 26. Nursing Horury at ork? Yes 2 No a 2 time, date and place, a opinion, death occurred	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 1 (Check only one) me 5 Residence 28d. Describe how in City or Town, St and due to the cause and at the time, date to	23d. Date of del Month o use contribute to 2 10 3 Pr 24b. Were au prior to 1 death? 1 Yes 6 Other (Special August 20 and Number or Rule) and Number or Rule ate) o(s) and manner as and place, and due Date signed (Month	Day Year to the cause of death? tobably 4 Unknown atopsy findings available completion of cause of 2 No cify) ural Route Number, s stated. to the cause(s) h. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** Lucile 03, 2005 7:54 A Stocks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges' If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/31/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2√2 F Months Yrs 82 228-38-7912 N. Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
and: If item 27 is marked other than "natural", or items 23s or 28a-f show the transmit or help transmit or each, the Medical Examination that the notities at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Execution or the contilled at 1 Yes 2 No Completed by Funeral Director P.G. MD Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5119 Temple Hills Road 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th Domestic Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jasper Cooper Lizzie Shephard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland Allen - Son 5119 Temple Hills Road; Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lincoln Cemetery 07/09/2005 Portsmouth, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur sel Funeral Service License 22. Name and Address of Facility
Freeman Funeral Services 6734 Hastings Drive; Marylam 22. Name and Address of Facility cications that caused the death. Do not enter the mode of dying, such as cardiac or respirat by arrest one cause on each line. 23a. Part1. Extended the disease, or composhock, or heart failure. List only of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit Due to (or as a cons Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2☑No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deatl Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 7 2005

MA

PESANMI

7503 Surratts Rd. Mcl

			1 - For State Registrar	State of Man	yland / Depa		Health and	Mental Hyg	•	26162			
	Physici /Medic		1. Decedent's Name (First, Middle, La Patricia Speled	s				2. Date of Deat Month July 3,	Day Year	3. Time of Death 11:30 &			
	Examir	er	4a. Facility Name (If not institution, giv				or Location of Deat		4c. County of Dea				
			Holy Cross Hos 5. Social Security Number 6. S		n yrs. last birthday)	Sil If Under 1 Year	ver Spri	_	Montgor				
	Funeral Director	5	79.42.9475 Usual Residence of Decedent	□M 2 🛣 91		Months Days Hours Min (Month Day Year) Country							
	Marylan a-f show	tor	10a. State 10b. County MD Montgome	i	Cc. City, Town or Lo Kensir					10d. Inside City Limits 1 ☐ Yes 🛣 No			
	3a or 28	i Dire	10e. Street and Number 4301 Knolls Aver	iue		10f. Zip Code	895	1	Og. Citizen of What Co	ountry?			
36	within 72 hours after death with the Maryland ene. than "naturat", or itams 23a or 28a-f show the Madical Examiner coust be notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	? If Yes, specify Cuban, Mexica No 1 ☐ Yes 2 No Specify			pecify Yes or No- o Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
15-00	in 72 hou n *natura dedical E	Completed	15. Decedent's Ed (Specify only highest great	ducation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	16b. Kind of Business	b. Kind of Business/Industry				
212	giene giene ar tha	Com	Elementary/Secondary (0-12)	I	THA Clerk			HUD					
Maryland 21215-0036	uld be file Vental Hy Irkad othi Ilic evant	To Be (17. Father's Name (First, Middle, Last, Theodore Speleos					ne (First, Middle, M abeth Kap	Maiden Surname) poutus				
Mar	od 2 sho lth and 27 Is ma traume		19a. Informant's Name/Relationship (Terry Droege/ Nie						City or Town, State,				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is merked othar than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State			
Ħ.			'4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Ferrice Licer	y)			etery 7/0		uitland, N ler's Sons				
Ba	Department impo		1 XIN	7. Bes	5	130 Wisc	onsin Av	enue NW W	DC 20016				
	Physician /Medical Examiner		23a. Parti. Enter the disease, or com shock, ordeart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Subarachn Due to (or as a c	oid Hemon		ng, such as cardiad	c or respiratory arre	est,	Approximate Interval Between Onset and Death			
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events	b. Cerebral Aneurysm Costo (oras a consequence on). Alzheimer's Dementia									
68760,	icate be executed physician and s the burial-transit	Ical Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of): Hypertension d.									
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ivision of Vita	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed							rmed? prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☐ No				
		tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ix inpatient 2 ENOutpatient 3 DOA 4 Nursing Home 5 Residence 6								
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, farm, str Specify)	reet, factory, office		reet and Number or Ri , State)	nt and Number or Rural Route Number, Rate)				
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier 1X Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of n ninar: On the basis of ex and manner state	ny knowledge, deat amination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	s stated. a to the cause(s)			
ŀ	To t Comp	W	29b. Signature and title of conflier	Shel	0	29c. Licens DO	062520		July 3, 2005				
	15		30. Name and address of person who			•	C#1 (Inmine M	D 20010				
	Sta Registi		Maria D'Arbela, 31. Date filed (Month) Pry. Year)	2005 32. Registrar's	Signature	ball	Silver	opring, M	m• 70310				

			For State Registrar	State of	Maryland.	-	artmen <i>rtificat</i>					giene No. (200		
	Physici		1. Decedent's Name (First, Middle, L		T THOMAS	STO	RER				2. Date of Dea Month July		2005	2:00	of Deekh 3
	/Medic Examir	er	4a. Facility Name (If not institution, give street and number) 7 Hammaker Street					4b. City, Town, or Location of Death Thurmont					4c. County of Death		
	Funeral Director		5. Social Security Number 216–22–6336 Usual Residence of Decedent	Sex 12 M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Jan. 7,	(, Year)	9. E 7 Ma	Birthplace (State Country) aryland	or Foreign
	ne Maryland Ba-f show	Director	10a. State 10b. County Maryland Freder	ick	10c. City, T	own or Lo	t							10d. Inside (City Limits s 2 ☐ No
	th with the 23a or 2	al Dire	10e. Street and Number 7 Hammaker Stree	t			10f. Zip		788			10g. Citize	on of What	•	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. od other than "natural", or tiema 23a or 28a-f show event, the Modical Evantinar must be rotified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	2 □ No	1	Was Deced If Yes, spec 1 Yes	**	spanic Ori n, Mexican Specify:		cify Yes or No- Rican, etc.)		1. Race - Ai Black, W Specify:	merican Indian, hite, etc. White	
	filed within 72 h Hygiene. Ither then "netu	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-		(Give life.	dent's Usua kind of wo DO NOT us State	rk done d se retired	luring mosi) oper			G	of Busines	,	
/land	2 should be fill and Mental Hy Is marked oth aumatic event	To Be	17. Father's Name (First, Middle, Las Ernest Thomas S						18. Mothe		(First, Middle, Ler	Maiden S	umame)		
Baltimore, Mary	and 2 sho eith and 1 27 is ma er traums		19a. Informant's Name/Relationship Ruby E. Storer /		1						Route Numbe				
	Pages 1 a ent of He nt: If Item ry or othe		20a. Method of Disposition **X Burial 2 Cremation 3 * 4 Donation 5 Other (Special Content of the Content of t				sition (Name of the least of th				2005		,	or Town, State Marylan	d
Balti	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any injury or other traumatic e ogoge.		21. Signature of Puneral Service Lice	ensee	t-	R ² C 61	BERT	d Addres	s of Facilit	¥ & S	ON FUNE	ERAL	HOMES	P.A.	_
	Physician /Medical Examiner	her	shock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate	a. Due to (c	one cause on each line.								Approxima Interval Be Onset and	tween Death	
.O. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	r as a consequen	ce of):									
	that the death certific ed by the attending p detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bir	ome of pregnancy th 2 Fetal dea nt at time of death wn	ath 3	Ectopic pro Other (sp.					23	d. Date of o	delivery Day	Year
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did to	acco use contribute to the cause of death				
Division of Vital Records,	n: The law requificate has been ir, page 2 should	Completed	Engh y Sal	na				_				ned? 20 No	prior to death'	autopsy findings o completion of ? es 2 \(\text{No} \)	available cause of
	Attending Phyaician: The Is r death. ector: Atter this certificate ha: by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner? 1												
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:								od Number or Rural Route Number, a)		nber,			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifier (Check only one) 29a Certifier (Check only one) Additional Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									s)			
)		2	29b. Signature and title of certifier Cut Itin	Por	~2			DO	96	89	2	9d. Date :	signed (Mo	nth, Day, Year)	
6	+IVA		30. Name and address of person who Austin Pearre,	Jr., 300	of death (Item 23 West 9t)	a) (Туре, n Sti	Print)	Fred	leric	k, MI	21701		,		
	Sta Registr		31. Date filed (Month, Day, Year)	1 2005 P	gistra's Signature	A		25							

			1 - For State Registrar	State of Mai		partmei <i>ertifica</i>			and M		giene	15	21.11.1.	
	Physici	an	Decedent's Name (First, Middle, Last) Samuel He	rman	Saylor					2. Date of Dea Month July	Day 1 2005	Year	3. Time of Death 6:15 A M	
	/Medic Examin		4a. Facility Name (If not institution, give s 10955 Green Valle	street and number)		4b. City, Town, or Location o				oury	4c. County	4c. County of Death Frederick		
	Funeral Director					Months Days Hours Min.				8. Date of Birth (Month, Day Aug. 2	Year) 1910	9. Birthplace (State or Foreign Country) Maryland		
	he Maryland Ba-f show	Director	Usual Residence of Decedent		10c. City, Town or Unic	r Location on Bri	dge					1	0d. Inside City Limits 1 ☐ Yes 2 🖔 No	
	3a or 2		10e. Street and Number 10955 Green Val	lev Rd.		10f. Z	ip Code 21 7	791		10g. Citizen of V	Vhat Cour	ntry?		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral		12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	ver in U.S. 1	I3. Was Deci	edent of Hi			cify Yes or No- Rican, etc.)	14. Race	k, White,	can Indian, etc. ite	
	d within 72 ho giene. er then "netur the Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(G lif	ecedent's Usi live kind of w le. DO NOT eter re	ork done d use retired	during most	t of workin	g g	16b. Kind of Bu		·	
yland	permit. Pages 1 and 2 should be filed 'Department of Health and Mental Hygic Important: If Item 27 is marked other any njury or other traumatic event, any ones.	To Be (17. Father's Name (First, Middle, Last) Roy Saylor							(First, Middle, e Schwa	Maiden Sumam arber	e)		
Mar		1	19a. Informant's Name/Relationship (Ty) Dennis O. Saylor			-					r, City or Town, Bridge		,	
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Di	sposition (Na	me of	e)	D	ate	20c. Location - Johnsvi	City or To	own, State	
Balt			21. Signal us of Puneral Service License Landwise 23. Part 1. Enter the disease, or compli	Harlist		11802	Libe	rty R	₹d.,	Liberty	Funeral	Hom D 21	e 762	
	The law requires that the death certificate be executed A Medical The has been signed by the attending physician and speed by the attending physician and speed for use as the buriat-iransiti	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First In Jury Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	Ja	h	uv	e el a	in C	Ġ.		Interval Between Onset and Death	
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic 5 □ Other (s					23d. Dat Moi	e of delive	ery Day Year	
٥.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa							23e. Did to	ne cause of death?			
al Records,	10	Completed									24a. Was an autopsy finding prior to completion death? 1 Yes 2 Vo 1 Yes 2 No			
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	t 2 ☐ ER/Outpa	ationt 2000	Oth	00		th (Check only one)				
ion of	or Attending ifter death. Director: After in by the fune	ertification; T	27. Manner of leath 12. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		of 28c. Injury at Work?			ome 5 Fasidence 6 □Other (Specify) 28d. ascribe how injury occurred			y)		
Division		0	3 Suicide 6 Could not be determined	building, etc. (Specify)							m, State)	al Route Number,		
	e Hospital 124 hours a le Funeral l letely filled	edical	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of a and manner state	examination and/o	eath occurre or investigatio	d at the tin n, in my o	ne, date an pinion, deal	d place, a th occurre	nd due to the old at the time, o	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)	
)	Marithin To the Compo	Me	29b. Signature and title of errifier	Bli	MD	7	Oc. License	number 3	30		29d. Date rigned	Month,	Day, Year)	
	W6		30. Name and address of person who co	meleted cause of de	ath (Item 23a) (Ty	pe, Print)	57	·)	u	Mon	BND	OR	191 MD	
:	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar		-	٠. مه	/)	

		For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mary		artment of H rtificate of L		2. Date of D	Reg. No.2005	2
Physicia /Medic Examin	al	4a. Facility Name (If not institution, give	Smith, Jr.		4b. City, Town, or	Location of De	Ju1y	6, 2005 4c. County of Dea	
Funeral Director		248-34-0151	14 200	n yrs. last birthday) 76 Yrs.	Rockvi If Under 1 Year Months Days	11e If Under 24 H Hours Mi	s. 8. Date of E	Montgom Birth Day, Year) 9. Bir Co , 1929 Ande	ery thplace (State or Foreign buntry) erson, SC.
e filed within 72 hours after death with the Maryland of Hygiene, of Hygiene, or Items 23a or 28e-f show yent, the Medical Examinational penditied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 1		Silver	Spring				10d. Inside City Limit 1 ☑ Yes 2 ☐ N
s 23a or 2	Funeral Directo	102 Belton Road	W. B. W. B		10f. Zip Code	20901	10 11 11	10g. Citizen of What Co	ates
be lied within 72 hours after death with the warylar be lied with 4/gione. I show the then "natural", or liems 23a or 28e-1 show event, its Medical Examinat must be notified at	2	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1950 to	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pui Specify:	(Specify Yes or ferto Rican, etc.)	No- 14. Race - Am Black, Whi Specify: B	te, etc.
then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occupa kind of work done o DO NOT use retired nief of Ot	turing most of w)		16b. Kind of Business Federal Go	,
Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) Robert P. Smith,				18. Mother's N		lle, Maiden Sumame)	y cermicite
m 27 is mand her treum		19a. Informant's Name/Relationship (Ty Vernelle D. Smith/	Spouse	102 H	Belton Rd;	Silve	r Spring		<u> </u>
perint. Tages I am Los should be in Department of Health and Mental H, Important: If tem 27 Is marked oth any injury or other treumatic even once.	9	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	iamova nom State	Harmony N	osition (Name of matory or other plac Iemorial I	Park Jul			MD.
Depar Impor any in		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	Vilely		2. Name and Addres		5538 M Forest	uneral Homes arlboro Pike ville, MD.	20747 Approximate
The law requires that the death certificate be executed The has been signed by the attending physician and Label 1 and	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last		onsequence of):	Accident				Interval Between Onset and Death
ine death certing ply the attending place as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of de Month	livery Day Year
oertificate has been signed by the a rector, page 2 should be detached f	Completed by	Part II. Other significant conditions co	ntributing to death but n	nat resulting in the u	inderlying cause givi			topsy prior to death? s 2 ⊠ No 1 □ Ye.	robably 4 Unknow utopsy findings availab completion of cause o
After this funeral di	ation: To Be	27. Manner of Death 1 25 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie	of 28c, Injun	er: 4 ☐ Nursing		y one) esidence 6 ⊠Other (Spe ee how injury occurred	Hospice
ospital or Attent hours after death unerel Director: ly filled in by the	Il Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc. (Specify)			City or 1	n (Street and Number or F Town, State)	
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier Time Certifier Pry (Check only one) 2 Medical Examination 29b. Signature and title of certifier	ner: On the basis of ex and manner stated	amination and/or in	n occurred at the tin envestigation, in my o	pinion, death o	ace, and due to the courred at the time	ne cause(s) and manner a se, date and place, and du 29d. Date signed (Mon	e to the cause(s)
2)111		30. Name and address of person who co	ompleted cause of death	h (Item 22a) (Tuna	D3563			1	2005
Sta	ate	Joseph Kaplan, 60 31. Date filed (Month, Day, Year) JUI 08 2005		er Mill F	1	ville, N	<u>ش. 208</u>	55	

			1_ State	epartment of Health and N	Mental Hygie	ne	
	4 11 1		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	2005	3. The of Death
	Physici	an	Ricardo Diechon Smith	Sr.	July 5	Day 2005	12:35 ^{P™}
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Death	
		er	1318 Ray Road	Hyattsville		Prince G	Georges
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	place (State or Foreign intry)
	Director		578-58-5709 1 □ RM 2 □ F 59 Yrs	i.	July 17	,1945 Wa	ish.D.C.
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	Maryli f sho	ō		attsville			1 ★ Yes 2 No
	the 1	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	3e or	Ö	1318 Ray Road	20782		U.S.A.	
	death	Funerai		13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White	ican Indian,
9	after or ite	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 전 No	1 ☐ Yes 2 ☐ No Specify:	,	Coocies	
g	filed within 72 hours after death with the Maryland Hygiene. tther than "natural", or items 23e or 28e-f show ont, the Medical Evantiner must be notified a	d by	3 Widowed 4 Divorced Year or Dates:	and antia United Consumation	161	B.J. Kind of Business/li	ack
21215-0036	n 72 *nat	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	king	, Killa of Businessyll	ndustry
2	withii ene. than	dwo	Elementary/Secondary (0·12) College (1-4or 5+)	Supervisor	G	ov.Dept	of State
ğ	other other	a	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
lar	ould be t Mental I larked or	To B	Norman S. Smith Sr.		Gloria E	• Ray	
Maryland	2 should be filed within 72 hours after death with the Marylan and Menhall Hygiene. and Menhall Hygiene is marked other than "natural, or items 23e or 28a-f show aumstic event, the Medical Examiner mast be notified at		1.1.1	lailing Address (Street and Number or Rui			
≥ ′	and ealth m 27 her tr				attsvill	e, MD . 20 / Location - City or T	
0	ges 1 t of H if Ite or ot		1 Burial 2 Cremation 3 Removal from State	crematory or other place)			
altimore,	it. Pa ritmen ritant: njury		* 4 □ Donation 5 □ Other (Specify) RIVELO 21. Signature of Funeral Service Licensee		7-2005Ri Hunt Fun		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		Transia B. Hunt	908 Kennedy St.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not				Approximate Interval Between
1.4	nysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	CThrouge			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	f Pharynx			
	Examiner		Samuration by Cancer O	f Pharynx			
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and and I-trans	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	certificate be executed rding physician and use as the buriat-transit	icai E					
687		edic	d.				
Box	eath certifi attending (I for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	2. Estable programmy		23d. Date of deliv	-
	000	icia	in the past 12 months? 1 Ves 2 No 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
J.	at the de by the a	hys	9 Unknown		an Didasha	co use contribute to	the saves of death?
_ <u>ທ</u> ົ	The law requires that the take has been signed by thoage 2 should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	1 ☐ Yes		bably 4 Unknown
Records,	w require been si should t	Completed			-		
Sec.	elaw hast je2s	mpi			24a. Was an autopsy performed	i? death?	opsy findings available ompletion of cause of
				00 Birrar / Bra	1 □ Yes 2★	No 1 ☐ Yes	2□ No
Vital		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other	th (Check only one)	a 6 ∏Other /Spec	ifv)
ō	ਦੂ ਦੂਲ		27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how i		,,
0	Attending P	atio	2 Accident investigation	M 1 Yes 2 No			
Division of	or Attendater deatl Director: In by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S		al Route Number,
	oitel o urs af ural D					-(-)	
	To the Hospitel or A within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Check only one	eath occurred at the time, date and place, ir investigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
) — (m)	MD 151 33	,	7/7/20	203
)	(10)		30. Name and address of person who completed cause of death (Tem 23a) (Ty				
	1		Raymon K.Nelson, M.D. 1160 Var	num St.N.E. Suit	e 208 Wa	ash.D.C.	20017
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				v
	Registr	ar	JUL 0 8 2005 Keeper & An	reft)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** July 5, Princess Josephine Simons 9:45 A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/2/22 Birthplece (State or Foreign Country) **Funeral** Months 1 □ M 2√2 F 83 Yrs. Director <u>577-22-5411</u> Wash.,D.C. Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itame 23a or 28a-f show the Medical Extender count be notified at 10d. Inside City Limits 1 XYes 2 ☐ No D.C. Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 3710 Grant Place, N.E. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after ☐ Yes 2, No Yes, Give 1 Never Married 2 Married African-1 ☐ Yes 25No Specify: \$ 3 Widowed 4 ☐ Divorced American Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Health Care Worker Laurel Childrens Center other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any ling yor other traumatic event sons. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Cole Robert Purdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fletcher J. Cambell/Son 841 50th Pl., N.E., Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/12/05 Landover, Md. 4 □ Donation 5 □ Other (Specify) Harmony Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 aug 14. JARO 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death de of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 2/2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (or sace or injury) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😧 No funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)45660 61

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

JUL 0 8 2005

4300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Singh, M. D.

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20-)1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month William Thomas Ora 0930M July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death eninsula 5 00 (4 If Under 24 Hrs. NICOMICO 6. Sex 1 **⊠** M 2 □ F 8. Date of Birth (Month, Day, Year) 11/10/1909 Birthplace (State or Foreign Country) Missouri 5. Social Security Number Days Min. 215-44-8753 95 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural" or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Eventinat marst be routiled at once. Baltimore, Maryland 21215-0036

For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral

Director

Physician /Medic Examir

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

within 24 hours after death.

To the Funerel Diractor: A

Division of Vital Records, P.O. Box 68760,

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tor	Maryland Wicomico	Salisbury			1X Yes 2 □ No
ai Dire	10e. Street and Number 511 Druid Hill Ave.	10f. Zip Code 21801	10	ng. Citizen of What Cor USA	untry?
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Pes 2 Was Decedent Armed Forces 1 Pes 3 W	? If Yes, specify Cuban, M	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	
mpieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Accountant	g most of working	16b. Kind of Business/I	ndustry
Be	12 4 17. Father's Name (First, Middle, Last) William Perry Thomas	18.	Mother's Name (First, Middle, M	faiden Sumame) Reeder	
To	19a. Informant's Name/Relationship (Type, Print) Larry Thomas/son	19b. Mailing Address (Street and I		City or Town, State, Z	ip Code)
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	20b. Place of Disposition (Name of cometery, crematory or other place) Salisbury Crematory	Date 2	20c. Location - City or 1	MD
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or as	d the death. Do not enter the mode of dving, su	l Rd., Salisbur	v. MD 21804	Approximate Interval Between Onset and Death 3
Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):			
ysician/Med		e of pregnancy 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)		23d. Date of delin	very Day Year
d by Ph	Part II. Other significant conditions contributing to death	out not resulting in the underlying cause given in		acco use contribute to	
complete	consisting heart	ladire	24a. Was an autopsy perform	prior to c death?	opsy findings available ompletion of cause of
o Be	25. Was case referred to medical / examiner? 1 Yes 2 LINo Hospital:	0.1	Place of Death (Check only one	9)	
ation; T	27. Manner of Death 1 CNartural 5 Pending (Month, D) 2 Accident investigation		28d. Describe ho		
Medical Certification;	4 Homicide Standard building, e	njury - At home, farm, street, lactory, office tc. (Specify)	City or Town,	_	
edical	one) 2 Medical Examiner: On the basis and manner s		n, death occurred at the time, da	ite and place, and due	to the cause(s)
×			5384 29	Od. Date signed (Month	* * * * * * * * * * * * * * * * * * * *
	30. Name and address of person who completed cause of	death (Item 23a) (Type, Print) SALISBURY MD	21804 Roda	en A Wenni	eh mà

State

31. Date filed (Month, Day, Year). JUL 0 8 2005

			1 - For State Registrar	State of Maryland	d / Depa			lental Hy	giene	OC	01:10
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	00	3. Time of Death
	Physici /Medio		Ernesto Tuzo	on				July 5	, 2005	Year	9:30а м
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death		4c. Coun	ty of Death	
			6409 Adak Street			Capito	l Heights		Prin		eorges
	Funeral		5. Social Security Number 6. Sex 11. (2)	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	00	170.			reb. 21	, 1939	Philli	pine Islands
	yland		10a. State 10b. County		, Town or Lo	ocation					10d. Inside City Limits
	e-f s	ctor	Maryland Prince G	eorge Ca	pitol	Heights					1K Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o	What Cou	ntry?
	ath w	Funeral Director	6409 Adak Street				20743		United		
	itams	nne	11. Marital Status 1. Never Married 2. Married 1. Married 2. Married 1. Marr	 Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No 195 		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ice - Ameri ack, White,	
336	urs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 196		1 ☐ Yes 2 🖾 No	Specify:		Spec	ity: As	sian
Š	be filed within 72 hours after death with the Maryland ital Hyglene. so other than "natural", or Itams 23e or 28e-f show event, Ita Madical Examinat must be ricillized at	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation		16b, Kind of	Business/Ir	idustry
21	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired					
21	e filed within at Hygiene. other than vent, II a Ma	Cou	llth		Mail	Operator	Facilita			nmen	
and	be fill	Be	17. Father's Name (First, Middle, Last) Hilario Tuzon				18. Mother's Name				
ž	should be ind Mental marked o	2	19a. Informant's Name/Relationship (Typ	o Print)	10h Maili	nn Address (Street	Euprecin				- 0- 1-1
Maryland 21215-0036	d 2 s Ith an 27 Is i		Elaine Tuzon/Spouse				and Number or Rura				
ē,	Heal Heal tem		20a. Method of Disposition	20b. Pf	ace of Dispo	osition (Name of	eet; Capi	COT Hel	20c. Location		
e E	Pages ent of nt: if i		1 ☑Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State Mar	yland	matory`or other plac Veterans	Cem. July	11,2005	Che1	enhar	n, MD.
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente Important: if item 27 Is marked any Injury or other traumatic e once.		21. Signature of Funeral Service License	9	22	2. Name and Addre	ss of Facility Po	pe Fun 538 Mar	eral Ho	mes	
m	Depa Impo any la		XIII CIS	ange MOLVS	75		F	orestvi	11e. MT	ike . 20	747
			23a. Part1. Effenthe disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardio P	ulma	mary	Arres	t			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		>				3
		70	Sequentially list conditions, b.	Due to (or as a consequence	C M	least	Diseas	L.			2 years.
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 20 2 00 100 40	0.100 017.						
Ć	exection and rial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cal	L d.								
9	entifica ing pt	Physician/Medical	IF FEMALE:					·			
Вох	leath certifics attending ph I for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnar	death 3[Ectopic pregnancy	,			ate of deliv	ery Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5	Other (specify)					July Vou
P.0	The law requires that the de tte has been signed by the a vage 2 should be detached f		Part II. Other significant conditions cont	ributing to death but not resu	Iting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
rds	w requires that s been signed t should be det	d by	Dilated Cardie	myapathy.	Ren	al failu	rc,	1 🗆 Y	es 2 No	3 Pro	oably 4 Unknown
S	law rec as bee 2 shou	lete	Pario Morral	vasinla	Dise	ase.		24a. Was	an 24b	. Were auto	opsy findings available
Re	The lav	Completed							med?	prior to co death? 1 \(\text{Yes} \)	mpletion of cause of
ital		Bec	25. Was case referred to medical examiner?				26. Place of Death			103	2010
of V	Physician: this certific ral director,	To	1 ☐ Yes 2 ☐No	ospital: 1 Inpatient 2 I	ER/Outpatier		4 Nursing Ho	me 5 Resid	lence 6 🗆 O	her (Speci	(y)
n c		inol	27. Manuer of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occu	rred	
isic	Attending ir death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ma form at		Yes 2 □ No	296 Location /6	Strant and Alum	there as Dua	al Route Number,
Division of Vital Records,	i or Attendater deatl Director:	Certification;	4 Homicide determined	building, etc. (Specify		reet, ractory, onice		City or Tow	n, State)	iber or Hun	al Houle Number,
_	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physi	cian: To the best of my know	viedge, deat	h occurred at the tir	me, date and place,	and due to the	cause(s) and n	nanner as s	itated.
	the Ho the Fu the Fu	edicai	(Check only 2 Medical Examinations)	er: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	pinion, death occurr	ed at the time,	date and place	, and due t	o the cause(s)
	To the I	ž	29b. Signature and title of certifier	5 50 1		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	(Q11.		JAN N	1. Crant	I'M	Do	27366		7/6	05	
1	(5/1V2		30. Name and address of person who con	. 4			1RVINED	NI	NEH 74	W)
	Sta	to	31. Date filed (Month, Day, Year)	Registrar's Signat	CBILE	Serak	(M) 3	XV TU	CV.		
	Regist		JUL 0 8 2005	Sie &	A	A.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day **Physician** Month JILY 8:20 AM JOHN ROLAND THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours JANUARY 27, 1952 XX™ MARYLAND 53 Director 214-58-2214 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Experience must be mailfied at 1 Yes 2 No Director MD **CHARLES** NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12460 SHILOH CHURCH ROAD 20664 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: δ 3 Widowed 4 N Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 POWER PLANT OPERATOR PUBLIC UTILITIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be \$2 should be f h and Mental H 7 is marked of JAMES THOMPSON MELROSE FORD THOMPSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELROSE THOMPSON/MOTHER 12460 SHILOH CHURCH ROAD, NEWBURG, MARYLAND 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SHILLOH UNITED METH. CHURCH JULY 9, 2005 NEWBURG, MARYLAND 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LYDIA C. THORNTON JOHNSON Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op spch line. Immediate Cause (Final disease or condition resulting in death) PRISIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medicai IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy perform 2 No 1 ☐ Yes o the Hospital or Attending Physicien: ector: After this certific by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 🗌 Yes 200 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check ont) onel 29b. Signature and title of certifier Coad, WALDORF, MD 20602 D0053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

ZAFAR ANSARI MD 7F POST OH MD 31. Date filed (Month, Day, Year) State JUL 0 8 2005 Registrar

)4 i			1 - State Unpend Item Registrar	State of Ma 23a, 27, 28	iryland i a-f pe	Depart	ment of 1845 7 ficate of	Health and 26-05 ta Death	Mental Hy s	giene Reg. No	2005	24151
	Physici		Decedent's Name (First, Middle, Last MATTHEW	ALLEN		TOLSO	N		2. Date of De Month July	ath Day		3. Time of Death 0738 A M
	/Medic Examin		4a. Facility Name (If not institution, give 626 Whispering Wir			(Gaithe		uth	4c.	County of Death	1
l ä	Funeral Director		5. Social Security Number 213-78-1192 6. Se Usual Residence of Decedent	x 7. Age M 2□F	(In yrs. last		If Under 1 Year Months Day		. (Month, Da	ay, Year)	Cou	nplace (State or Foreign untry) hington, D.C
breleash ode disc deep	lified at	ctor	10a. State 10b. County Md. Montgol	mery	•	own or Locat thersb						10d. fnside City Limits 1 ☑ Yes 2 ☐ No
đ đị đ	23a or 28	al Director	10e. Street and Number 626 Whispering	Wind Court	=		10f. Zip Code	20877			tizen of What Cou ited Sta	•
č	5 2 3	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			s Decedent o 'es, specify Cu Yes 2. M	f Hispanic Origin? (uban, Mexican, Pue o <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	D-	14. Race - Amer Black, White Specify:	
21215-0036	if Healing Should be they within 12 hours and if Healing had Mental Hygiene the Healing had the fire other treumetic avant, If a Mudical Evant other treumetic avant, If a Mudical Evant is a second other treumetic avant.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)			(Give kin	NOT use reti	ne during most of w	orking		ind of Business/I utomotiv	•
Maryland :	Mental Hyg mrked othe atic avant,	To Be C	17. Father's Name (First, Middle, Last) George Clarence	e Tolson				18. Mother's Na Betty	ame (First, Middle Hend		*	
, Mar	alth and a 27 is my er treum		19a. Informant's Name/Relationship (T Betty Tolson /			199 R	ollins	et and Number or F Avenue,		. ,		,
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,				ion (Name of tory or other p an Crei	1	Date 7/18/05		ocation - City or 1	
Balt	Department of Important: If says any injury or once.		21. Signature of Funeral Service Licens Murrief W	. Bar	her	/ 1	Muriel	tress of Facility H. Barbe Box 5038,	r Funera	l Ho svil	ome le, Md.	20882
	hysician /Medical xaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each tin a. Narcotic Due to (or as a	e. and A	Alcoho]			ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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ς ×	by the ettending prached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	eath 3⊟Eo	ctopic pregnar Other (specify)				23d. Date of deli Month	very Day Year
oras, r	been signed should be del		Part II. Dther significant conditions co	ntnbuting to death bu	ıt not resultir	ng in the unde	erlying cause	given in Part I.		Yes 2		the cause of death?
l Rec	ate has b	Completed							Yes	psy ormed? 2 \(\) No	prior to death?	topsy findings available completion of cause of
C 3	ig rinys ter this neral di	ation; To Be	27. Manner of Death 1 Natural 2 Accident y investigation	Hospital: 1 Inpatie 28a. Date of Injur Foundta. Day 7015-05	v 28		at 28c. In	Other: 4 Nursing	Home 5 Res	idence		unk
Division	io the nospitel or Atlental within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc Found a			t, factory, office	се	City or To	wn, State	nd Number or Ru e) 62 Whis sburg, N	ral Route Number, spering Wind laryland
1	ne nospi n 24 hour ha Funer sletely fill	edical	29a. Certifier (Check only one)	rsician: To the best of iner. On the basis of and manner sta	examination	edge, death o a and/or inves	stigation, in m	time, date and placy opinion, death oc	ce, and due to the	cause(s	and manner as	stated
) }	withi To the	M	29b. Signature and title of certifier Cabrill	ial A	LR-			M.E.			y 16, 20	**
			30. Name and address of person who can be seen and address of person who can be seen and address of person who can be seen as a seen and address of person who can be seen as a			3a) (Type, Pri		Street, B	altimore			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	and I						

			1 - For State Registrar	State of Mar	-	artment of H		Mental Hy	giene	0 0 00	24152
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of D Month	eath Da	y Year	
	/Medic	cal	Clarence Rudolph 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dec	July	-	005 . County of De	3:20am M
	Examir	ier	Casey House	street and number)		Rockvil		(II		ontgome	
	Funeral		5. Social Security Number 6. Se		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs				irthplace (State or Foreign Country)
п	Director		51/-12-6134	M 2□F	85 Yrs.	Months Days	Hours Min	Jan.	1, 19		ntana
	and w.		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	jo	Maryland Montgome		Germanto						1 ☐ Yes 2 🔀 No
	r 28a	Director	10e. Street and Number	<u> </u>	OCIMANICO	10f. Zip Code			10g. Ci	tizen of What C	Country?
	23a o	ai D	14010 Berryville F	Road		20874			Un	ited St	ates
	lams	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Wh	
36	rs afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 ½ No	Specify:			Specify:	
8	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itams 23a or 28a-f show The Medical Exatus as must be traffled at	ted k	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation		16b. K	and of Busines	White s/Industry
215	within 7; ene. than "n	pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	luring most of wo)	orking			,
2	a filed with I Hygiene. other than	Completed		2	Self	Employed			1-	eral Av	iation
and	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle	e, Maider	Sumame)	
Z Z	should be nd Mental marked o	T ₀	Joseph Ugrin 19a. Informant's Name/Relationship (T)	voe Print)	10h Mailir	ng Address (Street a		Pancich	hor Cibr	os Tours Stato	Zin Codel
Maryland 21215-0036	Ith an 27 is		Nancy Ugrin Bond	(Daughter		Berryvil					
re,	itam itam		20a. Method of Disposition		20b. Place of Dispo			Date		ocation - City o	
<u>m</u>	Page In a series		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		Custer Co	unty Ceme	terv 7/	11/05	Mile	s City	, Montana
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If itam 27 is marked any injury oppther traumatic and one.		21. Signature of Funeral Service Licens		22	Name and Address 0 East De	s of Facility	DeVol Fu	inera	1 Home	
	g 0 5 9 9		Menter 7. S.	Not							
			23a. Part1. Enjer the disease, or complete chock, or neart failure. List only of lmmediate Cause (Final	ne cause on each line.	e death. Do not ent	er the made or dying	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit	dical	•	Debility							
O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year
٥	requires that the een signed by th hould be detache	by Pf	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
Records,	w require been sig should b							1 🗆	Yes 2	Mo 3□F	Probabły 4 □Unknown
ecc	law asb 2sl	Completed						24a. Was	psy	prior to	autopsy findings available completion of cause of
E B	Th ate pag	Con						perf	ormed? 2 ☑ No	death? 1 ☐ Ye	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		t all poor Othe		ath (Check only			
of	Phys ar this eral di	n; To	1 ☐ Yes 2 🔀 No	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y		t 3 DOA 28c. Injury	4 🗆 (Vul Siriy I	Home 5 ☐ Res 28d. Describe			ecify) Hospice
ion	Attending I r death. actor: After by the funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(ear) Injury		:? /es 2 □ No				
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office		28f. Location City or To	Street ar	nd Number or F a)	Rural Route Number,
	he Mospit n 24 hour ha Funare	edical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of a ner: On the basis of ea and manner state	camination and/or inv	occurred at the time restigation, in my op	e, date and place pinion, death occ	e, and due to the urred at the time	cause(s date and) and manner a d place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of dertifier		1	29c. License	number		1 (te signed (Mon	
•	741		, - 1740	\sim \simeq	<u>ن</u>	D356	535		70	7 06	,2005
	•		30. Name and address of person who co				7111 M	n 20055			
	Sta	te	31. Date filed (Month, Day, Year)	01 Muncaste 32. pegistrar's	0:		vттте, М	ע עע			
	Registr		JUL 0 8 21	305 Angue	Signature	all!					

			1 - For State Registrar		ryland / Depa		Health and	Mental Hyg	_	24153
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Deat	h	3. Time of Death
1	Physici /Medio		PHYLLIS ELLETT	GRIM VI	CCELLIO			June	26 2005	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea		4c. County of De	
			Holy Cross Hosp	ital		Silver	Spring		Montgo	merv
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs			irthplace (State or Foreign Country)
	Director		226.14.8962	□M 2対F 8	4 Yrs.	Months Days	Hours Min	June 28		een Bay, VA
	D.		Usual Residence of Decedent							
	rylar		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e-f	cto	Maryland Montgo	mery	Silver S	pring				1. Yes 2 No
	or 28)ire	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	Country?
	th wi	Funeral Director	312 Apple Grove	Road		20904	į.		U.S.A.	
	ems ems	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh	
9	or It	正	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 🛛 N If Yes, Give	0	1 ☐ Yes 2 ☒ No		10 1 110411, 010.)	Specify: W	
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:		12103 223110	apacity.		Specify: W	mice
2	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show is Medical Evarting Frant for Indiffical an	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occu	during most of wo	orking .	16b. Kind of Busines	s/Industry
21	ithin her.	du	Elementary/Secondary (0-12)	College (1-4or 5-	life	DO NOT use retire	9d)		_	
12	led w lygier her ti			2 Years		Homemaker			Domesti	.c
<u>n</u>	be firal H d otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	faiden Sumame)	
yla	Men Men arke	ို		im				Young Be		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "naturel", or items 23e or 28e-f show may jury or other treumatic event, the Medical Evarchist reast the notified at once.		19a. Informant's Name/Relationship (City or Town, State,	
2	and ealth m 27		Lansing A. Vicce	llio/Husba						ryland 20904
Baltimore,	of H if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre.	osition (Name of matory or other pla	ісө)	Date 2	20c. Location - City o	or Town, State
<u>E</u>	Pag ment: ant:		'4 □ Donation 5 □ Other (Specific		Arlingto	n Nation	al Cem.7,	/27/2005	Arlington	, Virginia
alt	permit. Departm Importa any inju		21. Signature of Funeral Service Licer	968)	. 2	2. Name and Addr	ess of Facility	DAT HOME	TNG	
m	89 = 9		Nanny A.	Veam	- Î	1800 New	Hampshir	e Ave. Si	ling. 1ver Spri	ng, MD 20904
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that ceused	the death. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final		Arrhythmi	a				Onset and Death
7	/Medical		disease or condition resulting in death)	a	consequence of):					
	Examiner			Coronary	Artery D	isease				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that with and a second cause)	D	consequence of):					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	triat irritiated events	C						
ó	exection and and rial-tr		resulting in death) Last	Due to (or as a	consequence of):					
8760,	e be	Physician/Medicai		d						
9	ificat g phy as th	edi								
Вох	feath certifica attending phase as the	Z .	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	elivery
	death s atte	cia	in the past 12 months? 1 □ Yes 2 🕱 No	1 ☐ Live birth 2 4 ☐ Pregnant at t		⊒Ectopic pregnanc ☐ Other (specify) _	:у		Month	Day Year
P.0	the oy the	ys	9 Unknown	9□ Unknown						
	res that the de signed by the a be detached f	y P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	uires 1 sigr 1d be	d by	Non Insulin Depe	ndent Diab	etic Mell:	itus Typ	e 2	1 ☐ Ye	s 2⊠No 3∏F	Probably 4 Unknown
Records,	w requir been si should	Completed	Congestive Hear	Failuro				24a. Was ar	24h Wass	tanatiadiaaa ayailahta
æ	has ge 2	d E	Congestive hear	L railule				autopsy	prior to	autopsy findings available o completion of cause of
<u>=</u>	ician: The certificate he rector, page							1 ☐ Yes 2		es 2 No
Vital	Physician: r this certifica ral director, j	Be	25. Was case referred to medical examiner?	Hospital:			hor	ath (Check only one		
of	Phys this al dii	2	1 Yes 2 No 27. Manner of Death	1 Unpatier	t 2 ER/Outpatie	" JU DOA			nce 6 Other (Sp	ecify)
L C	ling Afte Iune	lo	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo		28d. Describe ho	w injury occurred	
Division	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 No	201 1 11 10		
Ξ	or At fter of Direction by	rtif	4 Homicide determined	building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		City or Town		Rural Route Number,
	urs a			4				Į.		
	Hosp 4 ho Fune Fune	ica	(Check only 2 Medical Exam	ysician: To the best on niner: On the basis of	examination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a ite and place, and du	as stated. ue to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medicai	Unay	and manner stat	ed.					
	With To	~	29b. Signature and title of certifier	- <i>M</i>		29c. Licen		29	d. Date signed (Mor	
,				WN		ט–ע	003792		6-	29-05
	10		30. Name and a dress of person who	completed cause of de	ath (Item 23a) (Type,	Print)	Court He	204 011		MD 20003
			Irnest S. Oser,		JI Georgia	Avenue,	Suite #3	504, S11V	er spring,	, FID 20902
	Sta Registi		31. Date filed (Month, Day, Year)	32. A egistra	r's Signature	parke				

1 -			1 - For State of Ma	-	artment of Health a ctificate of Death	and Mental H	lygiene	0000	
	Physic		1. Decedent's Name (First, Middle, Last) Rageim Lee	Wade		2. Date of Month JULY	Death Day 2	2005 Year	6:34 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) SHADY GROVE HOSPITAL		4b. City, Town, or Location of ROCKVILLE		40.	. County of Death	
	Funeral Director		175-74-1607 12 M 20 F	(In yrs. last birthday) 15 Yrs.	Months Days Hours	8. Date of (Month, Apr.	Birth Day, Year) 22,19	9. Birthpl Count PA	ace (State or Foreign try)
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town or Lo	cation thersburg			10	0d. Inside City Limits 1 Yes 2 □ No
	or 28e-1	Olrect	10e. Street and Number		10f. Zip Code		10g. Cit	izen of What Count	
036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "netural", or liems 23a or 28e-f show event, if a Medical Examiner must be motified at	by Funeral Director	732 Clopper Rd # 2	ever in U.S. 13. V	20878 Was Decedent of Hispanic Origin Yes, specify Cuban, Mexican I Yes 2 No Specify:	gin? (Specify Yes or , Puerto Rican, etc.)		U.S.A. 14. Race - America Black, White, e Specify: B.	
21215-0036	filed within 72 hor Hygiene. xther than "netura ant, It e M. of cell	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 th College (1-4or 5-	(Give	lent's Usual Occupation kind of work done during most DO NOT use retired) dent	-	Q1 Hi	ind of Business/Ind uince Oi gh Schoo	rchard
land	should be filed withir and Mental Hygiene. marked other than imatic event, It a M	To Be	17. Father's Name (First, Middle, Last) Sheldon R. Wade			r's Name <i>(First, Midd</i> nda Jone		Sumame)	
Maryland		-	19a. Informant's Name/Relationship (Type, Print) Linda Jones - Mother		g Address (Street and Number Clopper Rd				
	Pages 1 and 2 nent of Health int: If item 27 I ury or other tre		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place)	Date	20c. Lo	ocation - City or Tov	wn, State
Baltimore,	permit. Pages Department of I Important: If ite any Injury or or		21. Signaturi Funeral Service Licenses Leage Augustian	1 1 22	f Heaven Name and Address of Facility 46 N. Washin		Fun		ne.P.A.
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	1 -	er the mode of dying, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
)	Medical Examiner bhysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					
.O. Box 68760,	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
rds, P	signed be de	by	Part II. Other significant conditions contributing to death but	t not resulting in the un	derlying cause given in Part I.			ise contribute to the No 3 □ Proba	e cause of death?
Il Record	The law ete has b page 2 si	Completed				24a. W au pa 17 Yes	topsy rformed?	prior to com death?	sy findings available ipletion of cause of
Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No Hospital: 1 □ Inpatien	nt 2 🕅 ER/Outpatient	Other	of Death (Check only		6 □Other (Specify)	
on of		tlon: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury	28b. Time of	28c. Injury at Work? PM 1 □ Yes 2 🖼	28d. Describ	e how injur	y occurred	
Division	or Atten ifter deat Director: in by the	Certification;	2□ Suraida 6□ Could not be	ry - At home, farm, stre (Specify)	,	28f Location	(Street an	ON BY AND ON THE SELECT	Route Number
	Hospitel 24 hours a Funeral (edical C	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state	f my knowledge, death examination and/or inv	occurred at the time, date and estigation, in my opinion, deat	d place, and due to the	e cause(s) e, date and	and manner as sta place, and due to t	ted. the cause(s)
	To the Host within 24 ho To the Func	Med	29b. Signature and title of certifier	1	29c. License number OCME			e signed (Month, D	ay, Year)
•	2		30. Name and address of person who completed cause of de	~		eet Rolt-		3, 2005 , Maryland	d 21201
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Tegistrar 32. Tegistrar	7(1) r's Signature	ali reili str	cec nait.	THOTE,	, rarytail	1 41401

			for State Registrar		State o	f Maryl	and / Dep	artmen				ental Hy	_) [
			Registrar 1. Decedent's Name (First,	Middle, Last)			Tuncau	e oi Di	eaur		2. Date of De	Reg. Mg	005	-	3. Time of	Death
	Physici		Patricia P.								.,	Month uly 2	, 20		ar	5:15	
	/Medio Examir		4a. Facility Name (If not inst			m <i>ber)</i>		4b. City,	Town, or Lo	ocation o				. County of D	eath	3,123	
			Holy Cross	Hospi	taĺ				er Sp				M	ontgom	ery		
	Funeral		5. Social Security Number	6. Se	x □M 2□ x F		rrs. last birthday	If Under Months		If Under Hours	Min.	B. Date of Bir (Month, Da	ay, Year)	9.	Birthpla Counti	ice (State or	
	Director		553-12-5433 Usual Residence of Decede		Λ		85 Yrs.				C	ct. 1	, 19	19		Ore	egon
	yland		10a. State 10b. C	ounty	,	10c.	City, Town or L	ocation							10	d. Inside Cit	•
	e Mar	ctor	Maryland Mon	tgome	ry	Ве	thesda									1 ∏ Yes	2 No
	with th	Funeral Director	10e. Street and Number					10f. Zip						izen of What	Count	ry?	
	eath v	erai	5109 West Pa	th Co	12. Was Dec	edent Ever i	nIIS 13	208.		nanic Ori	ngin2 (Spec	ify Yes or No	U.S	.A.	merica	n Indian	
(0	r Item	Fun	1 Never Married 2	Married	Armed Fo 1 ☐ Yes	orces? 2 TarNo	110.0.	If Yes, spec	cify Cuban,	Mexican	n, Puerto R	ican, etc.)		Black, V			
93	rel', o	þ	3 🙀 Widowed 4 🗆 Div	orced	If Yes, Giv Year or D	ve lates:		1 🗆 Yes	2 No	Specify:				Specify: W	hit	е	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then *neturel; or items 23e or 28e-f show event, ite M. diral Extinities in usite to use the market of the	Completed	15. De (Specify only	cedent's Edu highest grad			(Giv	edent's Usua e kind of wo	rk done dur	on <i>ring</i> mos	t of workin	9	16b. K	ind of Busine	ess/Indu	ıstry	
12	withir ene. then	omo	Elementary/Secondary (0	-12)	College (1-4or 5+)	ille.	DO NOT us	altor				Re:	al Est	ate		
d 2	e filed al Hygie other vent,	Be C	17. Father's Name (First, M	iddle, Last)				1(0)		8. Mothe	er's Name	(First, Middle			acc		-
/lar	should be nd Mental marked o	To B	Norris Pouls	on					_]	Erna	Loen	nig					
Maryland	permit. Pages 1 and 2 should be Department of Health and Monta Importent: If item 27 is marked any injury or other treumetic as ODGS.		19a. Informant's Name/Rel	ationship (T)	ype, Print)		19b. Mai	ing Address	(Street and	d Numbe	er or Rural	Route Numb	er, City	or Town, Stat	e, Zip (Code)	
e, l	1 and Health em 27 ther t		Diana Rothma 20a Method of Disposition	n / Da	aughter		702 b. Place of Disp	Walnut		. S	anta			iforni ocation - City			
nor	nt of h		1 ☐ Burial 2 🖾 Crem			State	cemetery, cre	matory or o	ther place)	1	July 200	6,					
Baltimore,	artme orten injur		`4 □Donation 5 □ Ott 21. Signature of Fundaral Se			M	t. Comf							kandri 's Son			ша
ñ	Depar Depar Impor any in		Willia	in K	Bu	991						•		ningto	-		20016
			23a. Part1. Enter the disea shock, or heart failure	se, or comp List only o	lications that one cause on e	aused the d	leath. Do not er	nter the mod	e of dying,	such as	cardiac or	respiratory a	ırrest,		1 .	Approximate Interval Betw	ve <i>e</i> n
	Physician		Immediate Cause (Final disease or condition resulting in death)		Sepsis	3										Onset and D	eatn
	/Medical Examiner		resulting in death)				sequence of):										
	4	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying		Pseudo	Obst (crasason	ruction	Color	nic	-					+		
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		Lun (Cancer											
Ó,	e exection are in articular.		resulting in death) Last	- 1		`	sequence of):								Ţ		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai			_d Parkir	son's	Diseas	e									
9 xo	death certifica attending ph for use as the	/Med	IF FEMALE: 23b. Was decedent pregna		23c. If yes, ou	tcome of pre	gnancy		-					23d. Date of	deliver	4	
m.	death e atter d for u	iciar	in the past 12 months 1 Yes 2 No		4☐Pregr	oirth 2 🗆 F nant at time		□Ectopic pr □ Other <i>(sp</i>						Month			ear
P.0	that the do ed by the detached	Physician/M	9 Unknown	ŀ	9∐ Unkn												
Ś		by	Part II. Other significant co	enditions co	ntributing to d	eath but not	resulting in the	underlying c	ause given	in Part I	•		_	use contribut ☑ No 3 ☐			
orc	law requires as been sign 2 should be	eted					-		-					T			
Record	9 4 9	Completed										24a. Was auto perfe		24b. Were prior deat	to com	sy findings a pletion of ca	use of
Vital	ien: Th rtificate stor, pag	e Co	25. Was case referred to m	edical						26 Place	of Death	1 ☐ Yes (Check only	2 No	10	res 2	!□ No	
<u> </u>	ysic s ce direc	To B	examiner? 1 ☐ Yes 2 € No		Hospital:	Inpatient 2	2 🗌 ER/Outpatie	ent 3 DC	Other					6 □ Other (5	Specify)		
n of			27. Manner of Death	ending	28a. Date (Mon	of Injury th, Day Yea	28b. Time Injury	of 2	8c. Injury a Work?			d. Describe					
sio	ne all	icati	2 Accident	ould not be	OO - Disease	of laines	At home form	М		s 2 🗆		of Longtion	Ctroot	ad Alexantras a	. Oural	Davida Numb	200
Division	or Attendation after deati	Certification:	4 Homicide	determined	buildi	ing, etc. (Sp	At home, farm, s ecify)	treet, ractory	, onice		20	City or To		nd Number o	murai	LIOUTE MAINT	Θ/,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	dical C	29a. Certifier 1X Ce (Check only 2 ☐ Me	rtifying Phy	sician: To the	best of my	knowledge, dea	th occurred	at the time,	, date an	id place, ar	nd due to the	cause(s) and manne	r as sta	ted.	
	the Hin 24 the Fu	a a	one)		and man	ner stated.	nination and/or i					at the time,					
	To T	×	29b. Signature and title of c	entitier	.011		l.	0	: License n					te signed (M		ay, rear)	
•			30. Name and addres	School School	ompleted carry	mul so of dozen	1 / / / / / / / / / / / / / / / / / / /	1	4175	2			Ju1	y 2, 2	005		
	10		Bergit Scho				ish Meac		v Gai	ther	shur	z. Mar	vlan	d 2088	2		
	∟ Sta		31. Date filed (Month, Day,	Year 7 21	105 32	egistrar's S	ignature	and s)								
	Regist	rar	00L	V 1 2	100	Selle.	20. 79	100-6									

-04 n	461		For State Unpend Item Registrar						Mental Hy	giene	Jibic.		
	Post Control		Registrar 1. Decedent's Name (First, Middle, L		-r per	Cert	ificate of	Deathas	2. Date of Dea		005	21	156
1	Physici	_	Angela Wall	asi)					July	O2 ^y	2Ŏ05	4:15	A M
	/Medic Examin	_	4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of Dea		4c. Coun	ty of Death		
4	sei .	× ×	7990 Georgia Ave	nue	- /1	hitati i	Silve	Spring		Mo	ntgom	ery	
2	Funeral Director			Sex 7. Ag 1 ☐ M 2 🙀 F	e (In yrs. last 40	Yrs.	Months Days	Hours Mir	s. B. Date of Birth (Month, Day July 5,	r, Year)	9. Birthp Coun	lace (State d try) rginia	ir Foreign
7	in 6		Usual Residence of Decedent 10a. State 10b. County		10- Cir. T				ψ 01 j 3 ,	2301			
	r 28e-f ehow	ō			Toc. City, 1	own or Loca					'	0d. Inside C 1 XYes	-
	r 28e-	Director	DC 10e. Street and Number				10f. Zip Code	ington		10g. Citizen o	f What Coun	try?	
	23a or		1300 Sta	ples St., N	.E.			20002			ted S	tates	
	ter des Iteme	by Funeral	11. Marital Status 1X Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐		13. W	as Decedent of H Yes, specify Cubi	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- arto Rican, etc.)	14. R:	ace - Americ ack, White,		
036	hours aft		3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:	X 0	1 [⊒Yes 2. XTNo	Specify:		Spec	ify:	Black	
5-0	within 72 hours after deeth with the Maryland ene. then "natural", or teme 23a or 28e-f ehow the Modical Exaction man by notified at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	1	(Give ki	nt's Usual Occup nd of work done	during most of w	orking	16b. Kind of	Business/Inc	dustry	
121	within ene. then	jumo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO	O NOT use retired Unemp						
d 2	be filed withintal Hygiene.	Be Co	17. Father's Name (First, Middle, Las	st)			onemp.		ame (First, Middle,	Maiden Suma	ame)		
ylar	should be filed wind Mental Hygien marked other the imatic event, I.a.	ToB	David W	a11					Marg	gie Bro	oks		
Maryland 21215-0036	. A		19a. Informant's Name/Relationship Margie Wall		1	-			Rumal Route Numbe			Code)	
	an teel m 2		20a. Method of Disposition	11001101	20b. Place	e of Disposit	tion (Name of	1	Date	20c. Location		wn, State	
Baltimore,	permit. Pages 1 Department of F Important: If Ite any Injury or ot		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				t Cemete		9/2005	Wa	sh., I	OC	
alti	permit. Depertmine Imports any Inju		21. Signatur of Funeral Service Lic	ensee	4-		Name and Addre	ss of Facility	Stewart I				
	20 E # 9		23a. Part1. Exter the disease, or co	of and	Carlo de la la	1			d., N.E.		DC 20	JO19 Approximat	
760,	Physician / Medical Examiner partial-trausit	cai Examiner	Immediate dauke (Finaf disease or candition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. Cocaine Due to (or as b. Due to (or as c. Due to (or as	a consequen	ce of):	n					Onset and	Jeath
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	yslcian: T is certifice director, p	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2□ER	/Outpatient	3□ DOA Oth	00	eath Check only on Home 5 Resid	v	ther (Specify	at s	cene
Division of	Attending Physician: r death. ector: After this certifica by the funeral director.	ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	tound	$y' Y \Theta a r = 3$	b. Time of	28c. Injur Wor M 1	y at	28d. Describe h			nk	
Divis	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	DO - Diago of lai	ury - At home c. <i>(Specify)</i>	, farm, stree			28f. Location (S City or Tow Silver				Avenue
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			•	M.J.	K_		OC	rit. 		July 0	2,2005	;	
4	DC.		30. Name and address of person wh	o completed cause of d	leath (Item 23	Ba) (Type, Pi	111 Pe	nn Stree	et Balti	more, N	aryla:	nd 212	201
1	Sta		31. Date filed (Month, Day, Year)		ar's Signature	9							
E.	Registi	ar	JUL 1 5 2005	low N	Anna								

Physicia			st)				2. Date o		y Ye	3. Time of Dea
/Medic	al .		Lavon Witcher	r			July	10 10	200	05 10:10 A
Examin	er	4a. Facility Name (If not institution, give				, or Location of Dea	th	40	. County of D	Peath
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Funeral Director	8		□ M 2 X F 41	Yrs.	Months Day		. (Month	Birth Day, Year nber 1	.963 °. 6, Wa	Birthplace (State or Fo Country) Ashington, D
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be rediffed at	to	Maryland N/A	Ва	altimo	re					1 X Yes 2 □
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What	Country?
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me)	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Pue	Specify Yes o to Rican, etc.	No-		kmerican Indian, Vhite, etc.
al', or	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	1 □ Yes 2 X N	o Specify:			Specify:	Black
lical E	Completed	15. Decedent's Ec	ducation	16a. Deced	ient's Usual Occ	upation	ndeina	16b. K	ind of Busine	ess/Industry
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		12th grade		Pa	ra Legal	,	<i>(F)</i>			ito Dealers
od ot	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na				
marked marked matic ev	2	Rufus Garris	Type Print)	19h Mailin	o Address /Stre		L Dyir			ta Zin Codol
of Health and Ment litem 27 is marked r other treumatic e		19a informant's Name/Relationship (Tred Jones (Husb Carol Witcher Mc	and) Fadden (Mother)	4118	- 18th	Street N	F •Wa	chinat	on D	20018
item other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of		Date	20c. L	ocation - City	or Town, State
		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		natory or other p	tory, Inc	y 18,2		tevil	le,Maryland
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L			For State Registrer	State of	Marylan	-	irtment of H		nd Mental		000	01150
			Decedent's Name (First, Middle, Last)						2. Date	of Death	No.2 5	3. Time of Death
	Physici /Medic		Marie Whi							Ϋ́2,	2005 Year	11:10 P ^M
}	Examin	er	4a. Facility Name (If not institution, give s				4b. City, Town, or		Death		4c. County of Dea	
			PRINCE GEORGES HO 5. Social Security Number 6. Sex		Age (In yrs. i	last hirthday)	CHEVER	LY If Under 24	Hrs. 9 Date	of Rinth		GEORGES CO
	Funeral Director		1	M 2404F	80	Yrs.	Months Days		Min. 9/9	of Birth th, Oay, Ye / 24	ear) Wa	rthplace (State or Foreign Sh., D.C.
	pu ,		Usual Residence of Decedent									
	show	_	D.C. 10b. County		10c. City	y, Town or Lo						10d. Inside City Limits 1X Yes 2 □ No
	he M	ecto	10e. Street and Number			Wasiii	ngton					
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, Ita Madrel Examiral malled at	by Funeral Director	5084 Just St., N.	E.			10f. Zip Code	2001	9	109.	U.S.A	•
	death	nera	11. Marital Status	2. Was Deced Armed Ford	ent Ever in U.		Vas Decedent of His	spanic Origin	? (Specify Yes	or No-	14. Race - Arr	
36	s after or Ita	y Fu	1 Never Married 2 Married	1 Tes 2	™ No		Yes, specify Cubar	Specify:	ruerto Hican, et	C.)	Black, Wh	frican-
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15	- 4	piet	(Specify only highest grade	completed)	les 5 .)	(Give	kind of work done d OO NOT use retired)	urina most of	f working	D	ept. of	State
212	d within giene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4	or 5+)	Prin	ting Supe	erviso	r	U	.S. Gove	rnment
ठ	should be filed withir marked other than martic event, II a M.	Be	17. Father's Name (First, Middle, Last) Floyd Bennett						Name (First, M			
Z a	d Men narke	은		0.1.1								
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic evones.		19a. Informant's Name/Relationship (Typ. Serena J.M. Barnes/		er	1	g Address (Street a Alabama <i>1</i>					, ,
ē,	s 1 an I Heal Item 2 other		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	-	. Location - City o	
E	Pages ient of nt: If i		1 Burial 2 □ Cremation 3 □ Re 1 4 □ Donation 5 □ Other (Specify)	emoval from St	alb		oln Cem.		/9/05	Br	entwood,	Maryland
Baltimore,	partm porte porte y inju		21. Signature of Funeral Service License	າ _		-	Name and Addres	1 -				7
<u>m</u>	89589	4	X any W.	Snau	,	4	925 Burro	oughs 2	Ave., N.	E. Wa	shington	,D.C. 20019
10			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on ear	used the death th line.	h. Do not ente	er the mode of dying	, such as car	rdiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Head			WYTES					Oliset and Death
В	Examiner			Due to (o	ras a consequ	uence of);	Q.					
		Jer	Sequentially list conditions, if any, leading to immediate		ras a consequ	uence of):						
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50,	icate be executed physicien and s the burial-transit	edicai Examiner	resulting in death) Last	Due to (or	r as a consequ	uence of):						
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Box	death certif e attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 ponths? 1 \(\subseteq \text{ Yes} 2 \) \(\subseteq \text{ANO} \)	1□Live birt 4□ Pregnar	h 2∏Fetai nt at time of de	death 3	Ectopic pregnancy Other (specify)				Month	Day Year
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	law requires that the de as been signed by the a 2 should be detached t	by P	Part II. Dther significant conditions con	tributing to dea	th but not resi	ulting in the ur	derlying cause give	n in Part I.	23e.		2.1	to the cause of death?
ord	w require been sign	ted							_	1 Tes	2 (No 3 □ F	robably 4 Unknown
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alF	Th ate pag								100	performed Les 2		s 2 No
Ζij	Physicien: this certificant	o Be	25. Was case referred to medical examiner? YE Yes 2 No	ospital:		FD/0	Othe	~	Death (Check			
of	Phy er this eral d	\vdash	27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of	t 3X DOA 28c. Injury Work	4 Nursii			e 6 Other (Spanier)	ecify)
ion	Attending r death. ector: After by the funer	atio	1 □ Natural 5 □ Pending 2 Accident investigation	60000	Day Year)	Injury 10:30		? ′es 2⊠€No	pass	enger	- mobry	emele.
Division	er des recto by th	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	f Injury - At ho	ome, farm, stre	et, factory, office					lural Route Number,
	itel or irs afte rel Dir	O			strec				5000	Benning	hashington	De Ave SE
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Exemin	er: On the bas	is of examinat	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and p inion, death (blace, and due t	o the caus	e(s) and manner a	s stated.
	To the within 2. To the I complet	Med	29b. Signature and title of certifier	and manne	n Stated.		29c. License				Date signed (Mon	
	F 3 F 8		Jacob 3/1-	enf,	un		OCMI				лу 3, 20	
2 /	2			mplete cause	of death (Item	1 23a) (Type, I	Print)	C :				1 0100-
1		100	30. Name and address of person who co Tasha Z Gree w				III Penr	ı Stree	et Bal	timor	e, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	52. Re	gistrar's Signa	ture						

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5 3 A	Physic	ian	1. Decedent's Name (First, Middle, Last, Daa Tyah Washing		001	incate or i	Jean	2. Date of Dea Month	Day	3. Time of Death
).	/Medi Examii		4a. Facility Name (If not institution, give Prince George's Ho	street and number)	<u> </u>	4b. City, Town, or Cheve		June 2	4c. County	
92	Funeral Director		5. Social Security Number 6. Sec. 577–17–3802	7. Age (In yrs	7 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year) 1988	9. Birthplace (State or Foreign Country) Wash., DC
	the Maryland	ector		George's	ity, Town or Lo	Capito	ol Heigh	nts		10d. Inside City Limits 13 Yes 2 □ No
	th with t	al Dir	10e. Street and Number	ne, #302		10f. Zip Code	20743	1	Og. Citizen of W	What Country? Ted States
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow hy hours other treumatic event, the Medical Examinar must be routlled at ance.	d by Funeral Director	11. Marital Status 1 ঐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- arto Rican, etc.)	14. Race	e - American Indian, k, White, etc. African
21215-0036	vithin 72 hu ne. hen "natu e Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usuaf Occupa kind of work done of DO NOT use retired	furing most of w)	rorking	16b. Kind of Bu	
and 21	d be filed wantal Hygier to other the	Be	11th 17. Father's Name (First, Middle, Last) William H.	Ballard, Jr		igh Schoo		ame (First, Middle, I		
, Maryland	and 2 should saith and Me n 27 is mark er treumation	To	19a. Informant's Name/Relationship (Ty	rpe, Print) Jr./Father	19b. Mailin	Cindy La	ne. #30	Rural Route Number	City or Town,	State, Zip Code)
Baltimore,	Pages 1 ament of He tant: if itan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Denation 5 □ Other (Specify)	lemoval from State Maj	Place of Dispo cemetery, cren ryland	sition (Name of natory or other par National	k Mem. 7/	Date 6/2005	20c. Location - (Laur	City or Town, State el, MD
Bal	permit Depart import any in		21. Signatule of Funeral Service License	Lewart II	22			Stewart F ., N.E. W		
F.	Physician /Medical Examiner		23a. Part I. Enter the disease, or complishoot or leart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dea ne cause on each fine. Multi- Due to (or as a consec		be the mode of dying			est,	Approximate Interval Between Onset and Death
8760,	ate be executed tysicien end he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to anniectatic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect						
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. ff yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of the composition of the comp	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	o of delivery th Day Year
Ω.	w requires that been signed b should be deta	۵	Part II. Other significant conditions con	etributing to death but not res	sulting in the un	derlying cause give	n in Part I,			bute to the cause of death?
Vital Records,		e Completed	25. Was case referred to medical			7 250			y pr ned? de □ No 1	fere autopsy findings available for to completion of cause of path?
of Vi	Physicien: r this certific ral director,	To B	examiner? 1 ½ Yes 2 ☐ No		ER/Outpatient		r: 4 🗆 Nursing	eath <i>Check only one</i> Home 5 Reside		r (Specify)
Division o	or Attending after death. Director: Afte in by the fune	Certification:	27. Manner of Death 1 Naturaf 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury 2 (4)- ome, farm, stre fy)	28c. Injury Work 1 1 Y		28d. Describe ho	et sha	r or Rural Route Number
	Hospite 4 hours Funeral ely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and plac inion, death occ	e, and due to the ca urred at the time, da	use(s) and mail te and place, ar	ner as stated. and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	Hig mu	D	29c. License OCM			une 29,	(Month, Day, Year) 2005
4	(2)		30. Name and address of person who co THESDONEM, Ky			,	n Stree	t Baltim	ore, Man	ryland 21201
	Sta Registr		31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature	e.				

			1 - For State of Registrar	Maryland / Dep	artment of l			ene	21.160
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Walter Jerry White				2. Date of Death Month	Day Year 03 200	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and numi Pineview Nursing Home	ber)		or Location of Deat		4c. County of Dea Prince G	th
	Funeral Director		578-52-4061 1 X ^M 2 F	. Age (In yrs. last birthday) 65 Yrs.	Months Days			(ear) 9. Bir (739 N	thplace (State or Foreign buntry) EW York
	Maryland of show	tor	Usual Residence of Decedent 10a. State ND Price Georges	10c. City, Town or Le Capatal	ocation L Height	ts			10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28a Ist be nuti	al Director	10e. Street and Number 1309 Darwood Lane		10f. Zip Code 2074	13		G. Citizen of What Co United S	•
980	d within 72 hours after death with the Maryland liene. r then "naturel", or Itams 23a or 28a-f show the Modical Examiner must be nuitlied at	by Funeral	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced 12. Was Deced Armed Force 1 Yes, Give Year, Give	No No	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give life.	dent's Usual Occu e kind of work done DO NOT use retire	during most of wo	rking	Self-emp	
yland 2	be filled Ital Hyg Id otha avant,	o Be	17. Father's Name (First, Middle, Last) Walter Samuel White			18. Mother's Nat	me (First, Middle, Ma White	iden Sumame)	
Baltimore, Mar	os 1 and of Health itam 27 r othar ti		19a. Informant's Name/Relationship (Type, Print) Emmanuel Hammond / Son 20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	Bunnet A	ve. Suit			Town, State
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee				rray Fur ve. NW;Wa		me n DC 2001]
	Physician /Medical Examiner	ner	Due to (o	used the death. Do not enich line. Prof Panoras a consequence of): Onary Emboras a consequence of panoras a consequence	crease w				Approximate Interval Between Onset and Death
8760,	certificate be executed uding physician and use as the burial-transit	dical Examiner	that initiated events c. 1 1 Cu	ral Effusi rasaconsequence of):	on				
.O. Box 6	that the death certifice ed by the attending pt detached for use as t	Physician/Med	in the past 12 months?	nt at time of death 5	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
rds, P	sign d be	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	ınderiying cause gr	ven in Part I.			the cause of death?
al Record	The law ate has b page 2 si	Completed					24a. Was an autopsy performe	prior to	topsy findings available completion of cause of 2 No
ion of Vital	r Attanding Physician: Ther death. ractor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 Yes 27. Manner of Death 1 Natural 5 Pending (Month,	patient 2 ER/Outpatier Injury 28b. Time o Injury	of 28c. Inju	her: 4∰ Nursing ⊦ ry at	ath Check on one one 5 Residence 28d. Describe how		cify)
Division	al or Attancs after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place o building	f Injury - At home, farm, sti g, etc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner on the base and manner on the base of the certifier of	is of examination and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and title certifier)	29c. Licens	51520		Date signed (Monti	05
<u>C</u>	R3		30. Name and address of person who completed cause Buhraun Pishkad 98	of death (Item 23a) (Type,	Print) a Ave:	Suite 3	41 55	Md. &	0902
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0 7 2005	gistrar's Signature	ull				

			1 - For State Registrar	State of M	arylan	•	artmen rtificat			and M	-	giene Reg. No	00	15	21	16-
	Physici	an	1. Decedent's Name (First, Middle, Last)								Date of De. Month	ath Da	у	Year	Tirre o	of Death
	/Medic		Vera Frances	Wolf							July (_	2005	(5)	2:40	рм
	Examin	er	4a. Facility Name (If not institution, give s						Location o	of Death		1	. County o Yontgo i			
	Eupaval		Holy Cross Rehab. & N 5. Social Security Number 6. Sex			ast birthday)	If Under		If Under		8. Date of Bird (Month, Da				place (State	or Foreign
	Funeral Director			M 2⊠F	89	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept. 22	y, Year) , 1 91	15		ngton,	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c Cib	, Town or Lo	eation							1,	0d. Inside (City Limite
	shov	οľ	3.5			lver Sp										s 2½ No
	28a-f	Director	Maryland Montgomery 10e. Street and Number	<u></u>	51	Trer of	10f. Zip	Code				10g. Cit	lizen of WI	hat Cour	ntry?	
	3a or		15101 Peach Orchard	Road				20905					USA			
	daati	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-		- Americ	can Indian,	
36	or Ite		1 Never Married 2 Married	1 ☐ Yes 2X☐ If Yes, Give		1	1 🗆 Yes		Specify:		,		Specify:			
21215-0036	within 72 hours aftar death with the Maryland ene. then "natural", or Items 23e or 28e-f show Le Medicel Execition could be rodiffed at	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ition			16b. K	and of Bus	iness/în	dustry	
5	n "na	piet	(Specify only highest grade Elementary/Secondary (0-12)		5.1)	(Give	kind of wo DO NOT u	rk done a	urina mosi	t of worki	ng				,	
2	giena giena ar tha	Com	10	College (1-40)	J+)	Asse	mbly W	orker					Facto:	ry		
2	ba filed v tal Hygie d othar t	Be	17. Father's Name (First, Middle, Last)								(First, Middle, ingsford		Sumame)		
Maryland	Man Marke Marke	은	Montgomery Cornwell 19a. Informant's Name/Relationship (Type	na (Reige)		10h Mailie	A delta co	/Ctracto					Tour S	toto Zir	Codel	
<u>a</u>	d 2 st th and th s traur		Alford Wolf/ Son	De, Francj			-				Silver Sp				/ C00 0	
ē,	s 1 and 1 Haal		20a. Method of Disposition			lace of Dispo emetery, crer	sition (Nar	ne of	9)		Date	20c. L	ocation - C	City or To	own, State	
Ë	Paga Int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1 1	t Linco	-			200	, 9 , 15	Brent	,Loow	Mars	rland	
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show minipury or other traumatic event, the Medical Exaction for install be notified at once.		21. Sign was of Funeral Service License							Funer	al Home Silver	Inc		- 65		
			23a. Part I. Enter the disease, or complic	cayons that cause	d the death								19, 110	2050	Approxima	ate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each i Adenocar	ine.										Onset and	d Death
	/Medical		disease or condition resulting in death)	Due to (or as											J PDITC	I ID
	Examiner		Sequentially list conditions.													
	ad sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequ	uence of):								- 1		
	xacut and al-tran	Examiner	that initiated events cresulting in death) Last	Due to (or as	a consequ	uence of):								-		
1760,	icata ba axacutad physician and s tha burial-transit	cai	L d	.=												
89	tificat ng phy as th		luces with							-						
Вох	laath cartific attending p I for usa as I	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth			Ectopic pi	regnancy					23d. Date Mont		ery Day	Year
о. П	na daa tha at had fo	Physician/Med	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	it time of de	eath 5□	Other (sp	pecify)							<i>-</i>	
<u>α</u>	Tha law raquiras that tha daath cartifica tta has been signad by tha attending ph paga 2 should ba datachad for usa as it	/ Ph	Part II. Other significant conditions con	tributing to death !	out not resu	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did t	obacco	use contril	bute to t	he cause of	death?
rds,	quiras In signa	d by									10	Yes 2	⊠ No 3	3 🗌 Prot	ably 4]Unknown
Record	aw raquir as been si 2 should	Completed									24a. Was		24b. W	ere auto	psy findings mpletion of	s available
R	Tha tav	mo									autor perfo	rmed?	de	eath?	2 No	Cause of
Vital	ilclan: Th certificata ractor, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)				
of	shys this al dii	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	lospital: 1 Inpati		ER/Outpatier			4 🔼 190	_	me 5 🗌 Resident				(y)	
	ding h. Aftar funa	tion	1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Injury	M	28c. Injury Work 1 □ 1	ai ? (es 2 □ i		zod. Describe i	iow inta	y occurre	u		
Division	or Attanding after daath. Director: Afta In by tha funa	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho tc. (Specify	ome, farm, str	eet, factor	y, office			28f. Location (3 City or Tox			r or Rura	al Route Nu	mber,
	oltal or urs afte aral Dir illed in		***************************************													
	To the Hospital or Ati within 24 hours after of To the Funeral Direct complataly filled in by	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	ner: On the best ner: On the basis of and manner s	of examinat	wiedge, deati tion and/or in	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, i th occurr	and due to the ed at the time,	cause(s date and) and man d place, ar	ner as s nd due t	tated. o the cause	(s)
	To the within 2 To the complain	Me	29b. Signature and title of certifier	,			290	c. License	number 2481				ite signed		Day, Year)	
1	2		, A V	A				טט	2701			U	шу /,	2001		
	9		30. Name and address of person who co David Plotkin, M.D.	mpleted cause of 18111 Pr				Olney	, MD 2	20832						
	, Sta		31. Date filed (Month, Day, Year)			ture										
	Registi	ar	.101_0 8 200	J MARILE	1	15/100										

	*			State of							•		-egibi	e.		
			1 - For State Registrar	Olulo ol	ivial y lai		rtificate			21102 101		-	nn		21.100	
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	_		ear	3. Time of Death	
	Physici /Medic		Evelyn Margaretta	a Way							July	08	20		3:50 p ^M	
	Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location o	of Death	_	4c.	County of I	Death	•	
			Carroll Hospita 5. Social Security Number 6. Sex			last birthday)	If Under		minst If Under:		8. Date of Birtl		Car			_
	Funeral Director			M 2□ X F		73 Yrs.	Months	Days	Hours	Min.	Month, Day June 0	, Year)		Coun	ace (State or Foreign try)	
	ס		Usual Residence of Decedent			, ,					oune c	12_15	132		Ireland	
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the M	ecto	MD Carro	<u> </u>		Westm:	inste					10a Citis	en of Wha	1 Cour		_
	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f show ite Madical Examinatinual be notified at	by Funeral Director	225 Frock Drive	Apt. #2	220		101. 219		157			rog. Oitiz		JSA	y.	
	death ms 2:	nera		12. Was Decede	ent Ever in U	.S. 13.	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race -	Americ		_
9	or its	/ Fu	1 XNever Married 2 Married	1 Yes 2	20 No		1 ⊡ Yes 2		Specify:	i, Pueno i	rican, etc.)		Black, \ Specify:	wnite, o Whi		
Ö	hours tural',	d b	3 Widowed 4 Divorced	Year or Date	9s: 					-						
Maryland 21215-0036	in 72 "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	dent's Usua kind of wor DO NOT us	il Occupa rk done di se retired)	ition <i>Juring</i> most)	t of workin	ng	16b. Kin	d of Busin	iess/Inc	lustry	
212	d with giene. rr than	mo	Elementary/Secondary (0-12)	College (1-4	or 5+)	Rec	giste	red 1	Nurse			Nu	rsino	ĭ		
pu	i be filed within that Hygiene.	BeC	17. Father's Name (First, Middle, Last)								(First, Middle,			,		
yla	Menti arkec	To I	James McEvilly								rite Bo					
Mar	12 sh h and 7 Is m raum	1	19a. Informant's Name/Relationship (Ty) Robin Weisse/Attor	-			_				Route Numbe Je Wes					
	perrift. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itsms 23a or 28a-f show any njury or other traumatic event, the Mudical Examinating into the notified at once.		20a. Method of Disposition	.riey	20b. F	Place of Dispo					-		ation - Cit			_
JOIL I	ages ant of it; If it		1 ☐ Burial 2 ☐ X remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	ate [emetery, crer arroll			1		72005		moste			
Baltimore,	portar portar r njur		21. Signatu e ol neral Service Deense	90					-		e and C				TILD	-
ä	Department of the sany		Mall De	-							e and C West				21157	
i.			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cau	sed the deat	h. Do not <i>e</i> nt	er the mode	e of dying	g, such as	cardiac o	r respiratory arr	est,	CCI /	1.11	Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	ENG	5 57	ACE	C	OLO	2	CA	NCE	3			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):										
		-	Sequentially list conditions,	Due to for	A E C	uence off:	MET	LV	476	212				- 3	2+1700M	
	uted d ansit	Examiner	Sequentially list conditions, it any, leading cause. Enter Underlying Cause (Disease or injury that initiated events				Ε,	NC 6	Pun	100	1111	,		- 13	DRYS	
oʻ	te be executed ysician and te burial-transit		resulting in death) Last		as a conseq		1	100			12 (()				0. 13	-
3760,	a × a	licai														
89 ×	The law requires that the death certifical site has been signed by the attending phyage 2 should be detached for use as the	Med	IF FEMALE:	00.16.000.00.400										_		_
Вох	attend for us	Physician/M	in the past 12 months?		nne or pregna h 2 ⊟ Feta ntattime of d	Ideath 3	Ectopic pro					2	3d. Date of Month		ry Day Year	
P.O.	the de y the	ysic	1 ☐ Yes 2 /2 No 9 ☐ Unknown	9□ Unknow		eau S	J Other (Spi	sciry)								
٠, ص	s that ned b e deta	by PI	Part II. Other significant conditions con	tributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribu	te to th	e cause of death?	
rds	w require been sig should b	ed b									1 □ Y	es 2□	No 3[Proba	ably 4 Unknown	
Records,	law requas been 2 should	Completed									24a. Was a autops	sv	24b. Wer	e autop	sy findings available	
<u> </u>		Соп									perfor 1 ☐ Yes	med? 2 JA No	deat	h?	2□ No	
Vita	sician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	ospital: 🛶.				Othe	art .		(Check only or					
	Phy rat o	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		Bc. Injury	4 L Nui		ne 5 ☐ Reside 8d. Describe h			Specify)	-
Division of	ding Afte fune	ition	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month,	Day Year)	Injury	м	Work'	?` ′es 2.⊟1			ow injury	00001100			
N N	or Attencafter death Director: In by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		f Injury - At he , etc. (Specif	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Town		Number o	r Rural	Route Number,	
	rs after al Dir	Cert														
	Hospita 24 hours Funeral	edical	29a. Certifier Certifying Phys (Check only 2 Medical Examin	iar: On the bas	is of examina	wledge, death	n occurred a	at the time	e, date and inion, deat	d place, a th occurre	nd due to the c	ause(s) a late and	ind manne	or as sta	ited. the cause(s)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Med	one) 29b. Signature and title of certifier	and manne	r stated.			. License					signed (N			
1	Z Z Z S			Lohli					059	224	-	7/	11/0	_	-,1/	
	MIL		30. Name and address of person who co		of death (Item	23a) (Type.		,, 00	757			//				_
_	. 7		NIBHA KOHLI	680	0. C	POOLE	. 0 . 1	DA	W	EST	MINST	ER.	MD),	2157	
	Sta		31. Date filed (Month, Day, Year)		strar's Signa								,			_
	Registr	ar	JUL 1 1 2	טען	Mure	N. 16	barte	7								

			1 - For State Registrar		of Maryland	-	artmen rtificat			and M		jiene	<u> </u>	21.102
	Physici		1. Decedent's Name (First, Middle I rene Bowman	, ,							2. Date of Dea Month July	th Day	Year	5. Time of Death
	/Medio Examir		4a. Facility Name (If not institution		mber)		4b. City,	Town, or	Location of	of Death	July		2005 ounty of Dea	5:50P M
			Long View Nurs						ster				arroll	
	Funeral Director		5. Social Security Number 213-09-8540	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. Ia 90	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day March	Year)	9. Bin	thplace (State or Foreign buntry) ginia
			Usual Residence of Decedent									,,,,,,,		giiia
	ehow	o.	10a. State 10b. County Maryland Carro	11	,	Town or Lo								10d. Inside City Limits
	28a-1	rect	10e. Street and Number		146	2W W 111	10f. Zip	Code				0a. Citizer	of What Co	
	th with	ai Di	417 Church St.					2177	6			USA		,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-4 ehow any righty or other traumatic event, if a Madical Examiner must be in-lifted at ODGe.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 ※ Widowed 4 □ Divorced	Armed Fo	24∑No ve	1	Was Deced f Yes, spec l □ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit	e, etc.
9	72 hou natura	ted	15. Decedent	's Education		16a. Deced	lent's Usua	I Occupa	ition			16b. Kind	of Business	/Industry
<u> </u>	vithin 7 ne. han "r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us k/tre			or worki	ing	toun	2011015	nmant.
d 2	filed v Hygie other t		17. Father's Name (First, Middle,	Last)		CICI				r's Name	(First, Middle, i		gover	Timerru
rylan	hould be d Mental narkad c natic eve	To Be	Cornelius D. 19a. Informant's Name/Relationsi			105 14-15			Li1	llie	Ellen B	owmar	า	
, Ma	and 2 s salth an n 27 is i		Gilman Williar/			417	Churc	h St	. New		ndsor, M			cip Code)
Baltimore, Maryland 21215-0036	Pages 1 nent of H. ent: if iter ury or oth		20a. Method of Disposition *A □ Burial 2 □ Cremation *4 □ Donation 5 □ Other (S)		State Pip	ace of Dispo metery, cren De Cre	sition (Name natory or or ek Ce	ne of ther place mete	ry Ju				ion - City or vood ,	
Balt	permit. Departi Importi any inj		21. Signature of uneral Service	2. Xay	Seal	6	. Name and	road	s of Facility	Hart Unio	tzler Fu on Bridg	neral	Home 1. 217	91
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on e	each line.	Do not ente			, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque									- levi
	uted nsit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseque	ence of):								
8760,	ficate be executed physician and is the burial-transit	ai Exa	that initiated events resulting in death) Last	C. Due to	(or as a conseque	ence of):								
687	ificate g phys as the	edic		d										
.O. Box	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live b	tcome of pregnan pirth 2 Fetal of lant at time of dea lown	death 3	Ectopic pre Other (spe					23d.	. Date of deli Month	ivery Day Year
<u> </u>	quires that n signed b	by	Part II. Dther significant condition	ns contributing to de	eath but not resul	ting in the ur	nderlying ca	ause give	n in Part I.			acco use		the cause of death?
Division of Vital Records,	The law require te has been si age 2 should l	Completed									24a. Was a autops perform	y ned?	4b. Were au prior to death?	topsy findings available completion of cause of
Ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 Yes 2	B)	1 1 102	2 1190
of <	Physic this caldire	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death			R/Outpatient			INUI		ne 5□Reside			cify)
sion	Attending Physician: r death. ector: After this certifics by the funeral director,	Certification;	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	of Injury th, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work: 1 Y	at ? es 2□N	ło	28d. Describe ho			
N N	Hospital or Attend 24 hours after death Funaral Director: stely filled in by the	Certifi	4 Homicide determi	ned 286. Place	of Injury - At hom ng, etc. (Specify)		et, factory,	, office		2	28f. Location (St. City or Town	reet and N , State)	umber or Ru	ral Route Number,
		edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the examiner: On the ba and mann	best of my know asis of examinationer stated.	ledge, death on and/or inv	occurred a estigation,	in my opi	e, date and nion, deat	i place, a h occurre	and due to the ca ed at the time, da	use(s) and ite and pla	d manner as ce, and due	stated. to the cause(s)
	To the complete	Σ	29b. Signature and title of certifier	1			29c.	License	number 35(65	29	d. Date si	gned (Month	n, Day, Year)
_	3		30. Name and address of person	who completed caus	16-	23a) (Type, F	Print)	0.525	8-1	Va	-	1 2	is a	27:074
	Sta Registr		31. Date filed (Month, Day, Year)	8 2005 32. R	egisfar's Signatu	J.	Coord	ני				7		

			For State Registrar	State of N	/larylan	id / Depa	artment		and Me	ental Hyg	iene _{99. No} 2005	21, 161,
			1. Decedent's Name (First, Middle,	Last)					2	2. Date of Deat	h	3. Time of Death
	Physici /Medio		John Edward We	esley						July	5, 2005	1:30 P. M
	Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, To	wn, or Location	of Death		4c. County of Death	1
			Holy Cross Hos	spital				ilver S			Montgome	ery
	Funeral Director		578-68-2205	6. Sex 1 X M 2 ☐ F	Age (In yrs. 57	last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min.	Date of Birth (Month, Day, 6/20/4	Year) 9. Birth	place (State or Foreign intry) D.C
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "neturel", or Items 23a or 28a-f show event, the Mydical Evarifier must be notified at	ō	Md. Montgo	marv	T	akoma	Dark					MXYes 2 □ No
	r 28a	Director	10e. Street and Number	AIRCL Y		arona	10f. Zip C	ode		10	Og. Citizen of What Co	intry?
	h witi		7520 Maple Ave	enue # 714				20912			U.S.A	
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.	.S. 13.	Was Deceder	nt of Hispanic O Cuban, Mexico	rigin? (Spec	fy Yes or No-	14. Race - Amer	ican Indian,
9	after or ite	F.	1 Never Married 2 Marrie		No 166 I	60	1 ⊡Yes 2√5			can, etc.)	Black, White	, etc. cican–
8	urel',	d by	3 ☐ Widowed 4 ☐ Divorced		: 00-	00						erican
5	"net	iete	15. Decedent's (Specify only highest	s Education grade completed)		16a. Dece	dent's Usual (kind of work	Occupation done during mo	st of working		16b. Kind of Business/I Walter Rec	
21215-0036	within lene. than "	Completed	Elementary/Secondary (0-12) 12th	College (1-4o	r 5+)	Dir	ectora	done during mo retired) te of I al Serv	ogisti	cs lockeria	Medical Ca	enter
d 2	filed Hygid Sther		17. Father's Name (First, Middle, L	ast)		THIVIL	Ormineric				Latt Maiden Surname)	
Maryland	should be nd Mental marked o	To Be	Frank Henry We	eslev							tance Pharr	
ary	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (S				City or Town, State, Zi	
	C . E		Fay D. Glover/Si	ster		4309	3rd S	t.,S.E.	# 104	,Washir	ngton,D.C.	20032
ore	es 1 and of Health f item 27 r other t		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 Demonstra	20b. P	lace of Dispo	sition (Name	of er place)	Dai	е 2	20c. Location - City or T	own, State
Ē	Page ment ant: II		'4 □Donation 5 □ Other (Sp.		9	rmony 1			7/14/0	5 I	Landover, M	aryland
Baltimore,	permit. Pages: Department of H Important: If ite any injury or ot		21. Signature of Funeral Service L	censee		22	Name and	Address of Faci	lity	ne Co	Tno	
_	70 F # 9	Q1, 3	Many	W. GA	W	4	925 Bu	rroughs	Ave.,	N.E. Wa	Inc. ashington,D	.C. 20019
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caus nly one cause on each	ed the deatl line.	h. Do not ent	er the mode o	of dying, such a	s cardiac or i	espiratory arre	est,	Approximate Interval Between
	Pnysician	0.1	Immediate Cause (Final disease or condition	a End	Stare	Liver	Diseas	se				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a								
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	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated expets.	Due to (or a	is a conseq	uence or):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	is a consequ	uence of):						
8760,	icate be executed physician and s the burial-transit	ical										
9	death certificate e attending phys d for use as the	edic		0.				-				
Вох	eath certific attending pi for use as t	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Totalia asse				23d. Date of deliv	ery
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth			Ectopic preg Other (spec				Month	Day Year
P.0	law requires that the de as been signed by the z 2 should be detached i	Physician/Med	9 Unknown	9□ Unknown								
	signed be det	by F	Part II. Other significant condition	s contributing to death	but not resi	ulting in the ui	nderlying caus	se given in Part	l.		acco use contribute to	he cause of death?
ord	v requir	ted		-						1 _ Ye	s 2 No 3 Pro	oably 4 Unknown
Records,	e taw has b	Completed								24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
E	Th ate pag	Co								perform 1 ☐ Yes 2		2 🗆 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Plac	e of Death (Check only one)	
ō	Phys this ral dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of In		ER/Outpatien 28b. Time of		4 L N	-		nce 6 Other (Speci winjury occurred	(y)
O	Attending F r death. ector: After by the funera	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, D	ay Year)	Injury	M	Injury at Work? 1 ☐ Yes 2 ☐		J. Describe no	w injury occurred	
Division	Attender deatherder:	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of li	njury - At ho	ome, farm, str	eet, factory, o	110		Location (Str	eet and Number or Run	al Route Number.
ă		Certification;	4 Homicide determin	building,	atc. (Specify	1)				City or Town,	State)	
	Hospitel or Attend 24 hours after death 25 Funeral Director: stely filled in by the		29a. Certifier 1 Certifying	Physicien: To the bes	t of my kno	wledge, death	occurred at	the time, date a	nd place, and	d due to the car	use(s) and manner as s	stated.
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in	Medical	one) 2 Medical E	and manner s	or examinat	uon and/or inv	estigation, in	my opinion, de	ath occurred	at the time, da	te and place, and due t	o the cause(s)
	To the within 2.	Σ	29b. Signature and title of certifier	. /	A			icense number			d. Date signed (Month,	,
^	. 1		1/ Kun	Var	and)		D006189	90		July 6, 200	15
V	Va		30. Name and address of person w	. (1								
			Anuradha Dah. 31. Date filed (Month, Day, Year)		500 F trar's Signa	orest	Glen R	d.,Silv	er Spr	ing,Md.	20910	
	Sta Registr		JUL 0 8 20			Los	d.					
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Baltimore, Maryland 21215-0036

	Registrar			C	ertificate	of L	Death		Reg. No.	005	13	6
ian		•		- 1				Month		Year	3. Time	
Janice Hensley Walsh As Facility Name (If not institution, give street and number) 2816 Singerly Road Janice Hensley Sale Singerly Road Janice Hensley Janice Hens			5 A									
er	1. Decedent's Name (First, Middle, Last) Janice Hensley Walsh			Location of Death		_		aui				
December Name (First, Middle, Last) Janice Hensley Walsh Janice Hensley Jan		irthplace (State	or Forei									
State of Maryland / Department of Health and Mental Hyglene Certificate of Death Janice Hensley Walsh Janice Hensl		ennesse	e									
-			10c. Cit	ty, Town or	Location						10d. Inside	City Limi
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Dire		_										
- La		T	at Ever in II	18 1			panio Origin? (S	pocify Voc or No				
- nu		Armed Force	s?	.3.	If Yes, specif	ly Cuban	, Mexican, Puert	o Rican, etc.)				
۵		11 1 65, GIVE			1 ☐ Yes 2	X No	Specify:		S	pecify: W	hite	
eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		(G	ive kind of work	done du	uring most of wor	king	16b. Kind	of Busines	ss/Industry	
dmo	Elementary/Secondary (0-12)		r 5+)						Phys	ician	's Offi	ce
	17. Father's Name (First, Middle, Last				LIICC III	_		ne (First, Middle			B OILL	
<u>ල</u>	Ezra M. Hensley						Bertha	Ann Pra	ter			
		on	20h F									
	1 XBurial 2 ☐ Cremation 3 ☐		e Gi	ipin	Manor	ner place						
			Me			Address		_				
	1 med.	e. die	ha)		Hicks H 103 W.	ome Stoc	for Fun- kton St	erals, H reet, El	A. kton.	Marv	land 21	921
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the deat line.	th. Do not	enter the mode	of dying	, such as cardiad	or respiratory a	rrest,		Approxima Interval Be	ate etween
	disease or condition	a End	Sta	-10	Live	en	1215	20-5	2		Onset and	1 Death
	resulting in death)			Y								
ē	if any, leading to immediate	0.)						
ᄪ	Cause (Disease or injury	· H.	1POV	thy,	roil	-	m					
ш		Due to (or a	s conseq	uence of):	C.	./						
dica	•	d Alc	ohe	> (C	Cir	/ ME	2515					
/Me		23c. If yes, outcom	ne of pregna	ancy					236	d. Date of d	elivery	
clar	in the past 12 months?	4☐Pregnant	at time of d								Day	Year
hys		9∐Unknown										
2	Part II. Other significant conditions	contributing to death	but not res	sulting in the	e underlying ca	use givei	n in Part I.					death's
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	25 Was case referred to medical						26 Place of Dea			1 🗆 Ye	es 2 1 10	
0	examiner?	Hospital: 1 Inpa	tient 2	ER/Outpa	tient 3 DOA	Other	r			Other (Sp	ecify)	
		28a. Date of Ir (Month, L	jury Day Year)		e of 28	c. Injury Work	at ?	28d. Describe	now injury o	ccurred		
cati	2 Accident investigatio	Θ					es 2 No	29f Location (Ctront and h	lumbar a= 1	Burnt Bouto M.	mhc-
ertifi	dotominad	286. Place of	njury - At h etc. (Specif	ome, tarm, fy)	street, factory,	OTTICE				vuiti⊅⊖f Of F	nurai moute Nu	1100ľ,
a)												

Division of Vital Records, P.O. Box 68760, To the Hospit within 24 hours To the Funere completely fille

> State Registrar

31. Date filed (Month, Day, Year)

and title of centries

29b. Signature

30 Name and address of person who completed cause of death (Item 23a) (Typa, Print) 22. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** liui Mabel G. Ward /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 209-12-7475 80 Yrs. August 16, PA 1924 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumetic event. It's Medical Examiner must be notified at Director 1 ☐ Yes 2 No Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 168 Black Oak Road 17267 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after a and Mental Hygiene.
Is marked other then "naturel", or iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify Specify: 3 ☑Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Food Preparer County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Conard Smith Rebecca Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Importent: If item 27 Is eny injury or other treuonce. 12801 El l'aso l'rive Hagerstown, MJ 21742
Place of Disposition (Name of 20c. Location - City or Town, State Dawn M. Grimm/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) May's Chapel 07/15/05 Warfordsburg, PA 21. Sonature of Hineral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of sch line. Approximate Interval Between Onset and Death Immediate Cause (Final me Priysician disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tr resulting in death) Last Box 68760, Physician/Medical use IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mon Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 Yes Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and addre'ss of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 1138 Opal 32. Registrar's Signature State JUL 2 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			. For	State of I	Maryland	l / Depa	artment of H	lealth and	d Mental Hyg	giene		
			1 - State Registrar	,		Cei	tificate of I	Death	F	leg. No2 () ()5	26167
	Di-		1. Decedent's Name (First, Mic	Idle, Last)					2. Date of Dea Month /	th Day	Year	3. Time of Death
	Physici /Medi		Sarah	L. 2a	115K	4			7/	1/05	7041	7:20 PM
	Examir		4a. Fecility Name (If not institut	, , ,	er) .	' j	4b. City, Town, or	r Location of De	eath /	4c. County		Lor
			5. Social Security Number	eneral Ho	Age (In yrs. la	et hiethdowl	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birti	Wor		
	Funeral Director		194-01-0510	1 M 2 F	88	Yrs.	Months Days		in. (Month, Day 3 / 17 / 1	, Year)	PA	lace (State or Foreign try)
			Usual Residence of Decedent		00				3/1//1	917	FA	_
	rylan how		10a. State 10b. Cour	ity	10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	e Ma	Director	MD Wor	cester	Bis	shopv	ille					1 Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Coun	try?
	ath w		11912 Cedar				218			USA		
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	i. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race Black	- Americ k, White,	an Indian, etc.
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23e or 28e-f ehow ont, the Medical Exeminer must be notified at	by F	1 Never Married 2 M 3 XWidowed 4 Divorc	If Voe Give			1 ☐ Yes 2 № No	Specify:		Specify:	WE	nite
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<u>a</u>		2	Herman W. L	amb				Loi	s Troxell			
Maryland	01 00 0 0		19a. Informant's Name/Relatio	nship (Type, Print)					Rural Route Numbe			
≥, <	日本なに		Lynda Azar		looi. Bu	119	12 Cedai	r Creek	Rd., Bi			
Baltimore,	0 0		20a. Method of Disposition 1X Burial 2 ☐ Crematio	n 3 Removal from Sta		metery, cren	sition (Name of natory or other plac	(e)	Date	20c. Location - (City or To	wn, State
Ë	tmen tant: jury		`4 □Donation 5 □Other		Qua		Nat. Ce		16/2005			
3al	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service	ce Licensee	a. 4 !	1990	. Name and Addres		The Burb			Home
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Вох	death certifii e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnan 2 Fetal o		Ectopic pregnancy			23d. Date		
	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of dea		Other (specify)			Mon	ith	Day Year
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	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant cond	Itions contributing to death	but not result	ting in the ur	nderlying cause give	en in Part I.	1	/		e cause of death?
of Vital Records,	w require been sig	ompieted	100 101/130	// 3	Pair				1 □ Y	es 2LTNO	3 [P100	ably 4 🗍 Unknown
ec	e law has b	nple	-congestiv	e heart	tail	UPR			24a. Was a autop:	SV DI	rior to con	sy findings available apletion of cause of
E		S							perfor 1 ☐ Yes	med? 2 ☐ No 1	eath? □ Yes	2 No
Vita	iclan: Th certificete rector, pag	Be	25. Was case referred to medi examiner?	Hospital:			Oth		Death (Check only or	18)		
of	S 5	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Ir		R/Outpatien 28b. Time of		4 🗀 IAUI SIITQ	Home 5 Resid	ence 6 Othe)
uo	ding h. After fune	tion	1 ☐Natural 5 ☐ Pen		Day Year)	Injury	28c. Injun Work	yat k? Yes 2 □ No	28d. Describe II	ow injury occurre	3 4	
Division	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Cou	d not be	Injury - At hom	ne. farm. str	eet, factory, office		28f. Location (S	treet and Numbe	r or Rurai	Route Number.
<u>S</u>	f or At after of Direct In by	Certification:	4 Homicide	mined 286. Place of building,	etc. (Specify)				City or Tow	n, State)		
	To the Hospital or within 24 hours after To the Funerel Director Completely filled in the Funerel Completely Filled In the Fun		29a. Certifier 1☐ Certifi	ying Physician: To the be	st of my know	ledge, death	occurred at the tim	ne, date and pla	ace, and due to the c	ause(s) and mar	ner as sta	ated.
	ne Ho	edical	(Check only 2 Medic one)	al Examiner: On the basis and manner	of examination	on and/or inv	estigation, in my of	pinion, death oc	ccurred at the time, o	ate and place, a	nd due to	the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certi	fier / /			29c. License	-	and the second	9d. Date signed	(Month, L	Day, Year)
			Kustin	getype	n, r	10	C1-0	006-	795 -	7-10-0	05	
ī	i r		30. Name and address of person	on who completed cause o	f death (Item 2	23a) (Type,	Print)					AND E
, 1	1.5		KRISTINE GA	2150, M.	0 120	9 a	HAST AL	H16/12	- AY, FE	NUICK	156	AND 2
	Sta	16	31. Date filed (Month, Day, Yea	1 2005 32. Pagi	strar's Signatu	K A	medi					17799
	Registi	ar	JUL 3	TOTOP								

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 05 24 16 8	}
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 4:45 4. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	M
	Funeral Director		5. Social Security Number 6. Sex 12 Age (In yrs. last birthday) Months Days Hours Min. 7/23/1924 9. Birthplace (State or Fore Country) MD	ign
	the Maryland r 28a-f show notified at	Director	Usual Residence of Decedent 10a. State	
36	after death with or Items 23a or	by Funeral Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 11g. Citizen of What Country? 12g. Citizen of What Country? 13g. Citizen of What Country? 14g. Citizen of What Country? 15g. Citizen of What Country? 16g. Citizen of What Country? 17g. Citizen of What Country?	
21215-0036	s within 72 hours jiene. r than "natural", I'n Medical Ex.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Floor Technician 16b. Kind of Business/Industry Tile	
epn land	be filed stal Hygi od other avant, I	To Be Co	17. Father's Name (First, Middle, Last) Frank Zebec 18. Mother's Name (First, Middle, Maiden Sumame) Mary Schlonzak	
c, Jos e, Mar	nd 2 sho Ith and 27 is m		19a. Informant's Name/Relationship (Type, Print) Helen M. Zebec /wife 37358 Driftwood Dr., Greenbackville, VA 23356 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
Zebec, Baltimore,	permit. Pages Department of I Important: If it, any injury or o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Cape Henlopen Crem. 7/11/2005 Frankford, DE 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home	
	Physician		2/a. Part1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List dely one cause on each line. Immediate Cause (Final disease or condition a Choric Obstrictive primary disease under the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Usease under the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Usease or condition	
8760,	Medical Examiner hysician and he burial-transit	Ilcal Examiner	Due to (or as a consequence of): Sequentially list conditions, it as it, leading to immodiate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
P.O. Box 68	certific nding p use as	ompleted by Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
	law requires that the death as been signed by the atter 2 should be detached for u	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	wn
Vital Records,	The ate h	Complet	24a. Was an autopsy performed? performed? 1 yes 2 No 1	ole of
Division of Vita	ding Phy. h. After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1	
Divi	pital or urs afte aral Dir illed in I	al Certifi	4 Homicide determined determined determined 256. Place of injury: At nome, farm, street, factory, office 256. Education (Street and Number of Hural House Number) 256. Place of injury: At nome, farm, street, factory, office 256. Education (Street and Number of Hural House Number) 256. City or Town, State) 257. City or Town, State) 258. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To the Hosi within 24 ho To tha Fun completely f	Medical	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier County (Month, Dey, Year) C1-0006797 7-10-05	
<u>.</u>	1.3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRASTNE GRIFFINI D 1209 COASTAL ITGHUAY FENINCK ISLAND,	X
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	1

			For State Registrer	State of Mai		artment of rtificate of			Re	g. No. 20	05	24169
ì	Physici		1. Decedent's Name (First, Middle, La CHARLES J. BEE)	-					2. Date of Death Month JULY	Day 22, 20	Year 005	3. Time of Death 3:05 P.
	/Medic Examin		4a. Facility Name (If not institution, gire			4b. City, Town,				4c. County	of Death	
			2919 SALISBURY . 5. Social Security Number 6.		(In yrs. last birthday)	SPA If Under 1 Yea	RROWS		8. Date of Birth	BA	LTIMO	ORE place (State or Foreign
L	Funeral Director		212-52-8101	e/G₽34 2□ E	56 Yrs.	Months Day		Min.	(Month, Day, 9/12/19	Year) 48	Cou	ntry) RYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limits
	Mary B-f sh	tor	MD BALTI	MORE	SPARROW:	S POINT						1 ☐ Yes 2 ☐XNo
	vith the	Director	10e. Street and Number	*****		10f. Zip Code			10	Og. Citizen of V	Vhat Cou	ntry?
	eath v	erai	2919 SALISBURY	AVENUE 12. Was Decedent Ev	ver in U.S. 13.	212 Was Decedent of		igin? (Spe	cify Yes or No-	USA 14. Rac	e - Ameri	can Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinations to collinate.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: V		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 N			Rican, etc.)	Specify	k, White,	
2-0	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual Occ kind of work don	ne durina mos	t of workir	ng	16b. Kind of Bu	usiness/Ir	ndustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use reti NAGER	red)			BOOK .	STORI	E
	al Hygie I other vent,	Be C	17. Father's Name (First, Middle, Las						(First, Middle, N		ne)	
Maryland	2 should be and Mental is marked o	To T	CHARLES J. BEER		105 14-16				ET ISENC		State 7	- Codal
Ma	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship MARGARET BEERS/			ng Address (Stre			APT. T-2			~21234 E. MD
ore,	ges 1 and 2 it of Health if item 27 l or other tra		20a. Method of Disposition 1 Derial 2 A Cremation 3		20b. Place of Dispo		I		-	20c. Location -		
altimore,	Pages tment of lant: if it		* 4 ☐ Donation 5 ☐ Other (Spec	fy)	METRO CRI					CATONS		
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Furier I Service Lice	nsee		2. Name and Add						OME, P.A. 286
г	×		23 Part1 Enter the disease, or cor shock, or heart failure. List only	nplications that caused to one cause on each line	he death. Do not en	er the mode of d	ying, such as	cardiac o	r respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Colo	^ -	cea						Onset and Death 2 Months
	/Medical Examiner			Due to (or as a	consequence of):	Poxito	. His) days
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a	consequence of):	1000	NIO 13					any
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):			_				
8760,	cate be executed oblysician and the burial-transit	calE	· ·	d								
9	ertifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of	f pragnancy			d. attic		001 5		
S. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnar Other (specify)				Mo	e of deliv	Day Year
P.O.	res that th igned by be detach	y Phy	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause	given in Part I	l.	23e. Did tob	acco use cont	ribute to t	the cause of death?
rds	v requires been sign should be	ed by							1 ☐ Ye	s 2 TNo	3 Pro	babiy 4 ∐Unknown
Division of Vital Records,	2 3 8	Completed							24a. Was ar autopsy perform 1 Yes 2	red?	Were autorior to co death?	opsy findings available ompletion of cause of
ital	stiffical ctor, p	Be C	25. Was case referred to medical examiner?						(Check only one	9)		2010
of <	Physic this ce al dire	ို	1 Yes 2 No	Hospital: 1 Inpatient					ne 5 reside 28d. Describe ho			fy)
lon	Attending Physician: r death. ector: After this certific	ation	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day	Year) Injury	W	Vork? ☐ Yes 2 ☐		.og. Describe no	w injury occurr	00	
Divisi	i or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not determined		y - At home, farm, st (Specify)	reet, factory, offic	e	2	8f. Location (Str City or Town	reet and Numb , State)	er or Run	al Route Number,
-	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		hysician: To the best of miner: On the basis of e and manner state	my knowledge, deal examination and/or in ed.	h occurred at the vestigation, in my	time, date ar y opinion, dea	nd place, a ath occurre	and due to the ca	use(s) and ma ite and place,	nner as s and due t	stated. to the cause(s)
}	To the within to the comple	Me	29b. Signature and title of certifier	ups mo		29c. Lice	onse number	1699	58 29	7/25	(Month)	Day, Year)
•	J//		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print) Avenu	ne.	Ba	Utinore	MO	21:	224
	Sta		31. Date filed (Month, Day, Year)	32. degistrar	's Signature	never)						
	Regist	al	JUL 25	UUU A CHANG								

	212	1. Decedent's Name (First, Middle, Las	rt)			_		2. Date of De	ath Day	Year.	3 Time of Death
Physici /Medio		Dania	Sheb	a	1	ank		June	132	005	1300 gm
Examir	er	4a. Facility Name (If not institution, give	1 11		-		Location of Dea	th	4c. County	of Death	,
uneral		5. Social Security Number 6. S		pr. (Pr.C.) yrs. last birthday)	If Under	1 Year	If Under 24 Hrs	8. Data of Bir	th	9. Birthpla	ice (State or Foreign
irector		214-62-5051	□M 2X)F 5	3" Yrs.	Months	Days	Hours Min	8. Data of Bir (Month, Da	5 51	Countr	<u> </u>
*		Usual Residence of Decedent 10a, State 10b, County	10c	. City, Town or Lo	ocation					100	d. Inside City Limits
-f sho	tor	MD NA		Baltimo	ore						XXYes 2 No
item 27 is marked other than "neturel", or items 23s or 28e-f show other traumatic event, it a Medical Exercit at Frant be notified at	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of V	Vhat Countr	y?
Wat b	ral	4415 Old Fred					229		U.S		
1	Funeral	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Rac Blac	e - Americar k, White, et	
DEC.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XTX No If Yes, Give Year or Dates:		1 ☐ Yes 2	2 ∑ No	Specify:		Specify	Bla	ack
CM	Completed	15. Decedent's Ed (Specify only highest gra	ucation	(Give	dent's Usua	k done o	during most of wa	rkina	16b. Kind of Bu		
M M	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)		Baltimore, Mc 20c. Location - City or Town, State 20c. Location - City or Town, State Haltimore Co imore, Md 212 Approximatest, Approximatest, Approximatest, Approximatest Appr		
ut'		11th grade 17. Father's Name (First, Middle, Last)	na	Buil	ding	Ser	vice W				ools
C 8V8	To Be	Paul Toliver S	r.				Mozell			-/	
umat	F	19a. Informant's Name/Relationship (7			-				-		
other tra		Lark Cooper-Si							Baltim	ore,	Md 21229
-		20a. Method of Disposition XXBurial 2 Cremation 3	Removal from State	b. Place of Dispo cemetery, cre	osition (Nam matory or o	ne of ther place	e)	Date	20c. Location -	City or Tow	n, State
dati		`4 □Donation 5 □ Other (Specify		Woodla				8/05	Ealtim	ore (Co, Md
any injury o		21. Signature of Funeral Service Licen	see k	M	arch	F/H	west	D-1+-		ма '	21215
		23a. Parti. Enter the osease, or comp	plications that caused the c							-	Approximate nterval Between
cian.		shock, or heart failure. List only immediate Cause (Final	one cause on each line.	Pneumo	mia	Magazar	en since		1	ë.	Onset and Death
ical		disease or condition resulting in death)	a Due to (or as a con	sequence of):	proc	C m lo		1	V		
ner	L	Sequentially list conditions,	b. Intens	1 mal	abet		chica	0/	- Var	INER	
í	njne	Sequentially list conditions, if any, leading to immediate East any in Cause (Disease or injury	Due to (or as a con	sequence or):					OV MEDICAL ENT		
ial-tra	Examiner	that initiated events resulting in death) Last	cDue to (or as a con	sequence of):				WAPROTE	70.		
he burial-transit	cal		d				ERI	CATRO			
for use as the	Physician/Medi	IF FEMALE:		V-11							
3	ian/	in the past 12 months?	23c. If yes, outcome of pre 1☐Live birth 2☐F 4☐Pregnant at time	Fetal death 3	Ectopic pre						
tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ordeatti 5L	_ Other (spe	эспу)					
ne oeg	by Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying ca	ause give	n in Part I.	23e. Did to	obacco use contr	ibute to the	cause of death?
d blu	ed b	Hydroco phalus	, cinexic i	encenho	depan	thy		101	res 212No	3 Probab	oly 4 □Unknown
ge 2 should b	plet	Respiratory Ja	iluc . P	araple	910			24a. Was	sv E	rior to come	y findings available
pa	Completed	Paraplegia due to	cervical s	oine les	ion			1 Yes	rmed?	eath?	
rector,	Be	25. Was case referred to medical	Unanital:			A Othe	NP.	ath (Check only o			
5	.: To	1 XYes 25 No	1 ☑ Inpatient : 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o		Bc. Injury Work	4 Nuising	dome 5 Resident	dence 6 Other		
tunera	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury	м		(? Yes 2 □ No				
0	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory	, office		28f. Location (S City or Tox	Street and Numbern, State)	er or Rural F	Route Number,
en ta	E		, , , , , , , , , , , , , , , , , , , ,								
by the	S		ysician: To the best of my	knowledge, deat	h occurred a	at the tim in my op	e, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as statended to the	ed. ne cause(s)
by the		(Check only 2 Madicel Exam	liner: On the basis of exan								
by the	Medical Ce	(Check only 2 Madicel Examone)	and manner stated.			License	number		29d. Date signed	Month, Da	ay, Year)
e in G	edical	(Check only 2 Madicel Exam	and manner stated.						29d. Date signed		ay, Year)
completely tilled in by the t	edical	(Check only 2 Madicel Examone)	and manner stated.	Alm	29c.	D3	1	D 2123	E / 13 1		ay, Year)

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" ~ " any injury or other traumatic even."

use as the burial-transit attending physician and for use as the burial-tran Š certificate has been signed l rector, page 2 should be det funeral director Diractor:

To the Hospital or Attanding Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ec	topic preg ther (spec			23d. Date of delivery Month Day Year
ompleted by Ph	Part II. Other significant conditions of Rospuratory	ontributing to death but not res			se givenin Parti	23e. Did tobacco	24b. Were autopsy findings available prior to completion of cause of death?
Be C	25. Was case referred to medical examiner?					ath (Check only one)	
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA	Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Specify)
ation:	27. Mannar of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c	Injury at Work? 1 Yes 2 No	28d. Describe how inj	ury occurred
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fy)	factory, o	ffice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
dical (ysician: To the best of my kniner: On the basis of examinating					s) and manner as stated. nd place, and due to the cause(s)

29c. License number

3912

Eutan ST. Baltimore MD 21201

29d. Date signed (Month, Day, Year)

7/19/2005

Registrar DHMH 17 Rev 1/2001

State

within 24 hours after To the Funeral Direct

29b. Signature and title of certifies

31. Date filed (Month, Day, Year)

A-AHMED MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

NASTA

32. Regetrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #1 PER PHY G845 9925 1935 Peath Reg. No. 2 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death JOSEPH BERGER LEONARD Month Dav **Physician** /Medical 00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2723 Hambleton Road Riva Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 16, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**√**M 2□F 212-22-7719 Maryland 78 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Mudical Examining might be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2723 Hambleton Road 21140 United States 12. Was Decedent Ever in U.S.
Agned Forces?
11 ★ Yes 2 □ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or lien any injury or other traumatic event, Ite Medical angone. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Berger Bertha Bernice Somborski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Berger (Nephew) 2723 Hambleton Road Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 7/22/05 Oak Lawn Cemetery Balitmore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** abheimen type demen Hears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy real. 2 No 1 Yes I or Attanding Physician: after death. Diractor: After this certifica led to medi uneral director, 25. Was case reexaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 17 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital 29a. Certifie 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 145297

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

31 Robinson Road

32. Registrar's Signature

Severna Park, MD 21146-2841

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elaine M. Arata, M.D.

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	aryland / Depa	artment of F rtificate of			Reg. No.2	5 21 172		
I	Physici /Medic		Decedent's Name (First, Middle, Last MARY JE) IAN SANK	ER BERGE	R		2. Date of De Month JULY	Day 200	Gear 3:00 P. M		
	Examin		4a. Facility Name (If not institution, give 700 CAMBERLY CIR				r Location of Deat	h	4c. County of	Death ALTIMORE		
	Funeral Director		5. Social Security Number 6. Se 105-16-2226		9 (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 04-23	th ay, Year) -1924	D. Birthplace (State or Foreign Country) PENNSYLVANIA		
	aryland show		Usual Residence of Decedent 10a. State 10b. County MD. BALTIN	MODE.	10c. City, Town or Lo	ocation TOWSO) N			10d. Inside City Limits 1 ☐ Yes 2(1) No		
	th the Mi or 28a-f	Jirecto	10e. Street and Number 10e. Street and Number 10f. Zip Code						10g. Citizen of Wh	at Country?		
9	hours after death with the Maryland turel', or flems 23a or 28a-f show al Examiner must be notified at	Funeral Director	700 CAMBERLY CIR 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 Yes 2XX	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub.		Specify Yes or No to Rican, etc.)	U.S 14. Race - Black, Specify:	American Indian, White, etc. WHITE		
21215-0036	72 B 13	Completed by	3 ☐ Widowed 4 Novorced Year or Dates:						16b. Kind of Business/Indus			
ind 212	ild be filed within lental Hygiene. ked other than " ifc svent, the Was	Be	12 YEARS 17. Father's Name (First, Middle, Last) EUGENE		EXEC	UTIVE S			, Maiden Sumame)	CE COMPANY		
faryla	d 2 should th and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Maili		and Number or R	ural Route Numb	er, City or Town, St. MARYLANI			
Baltimore, Maryland	of Heal		ANNE E. HANNON (F 20a. Method of Disposition **YBurial 2 Cremation 3 III **4 Donation 5 Other (Specify	RIEND)	20b. Place of Dispe	osition (Name of matory or other pla	се)	Date 7-2005	20c. Location - Ci			
Baltir	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licens		2	2. Name and Addre	ess of Facility			O YORK ROAD SON,MD.21204		
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	ne.	cardiac	1	brespiratory a		Approximate Interval Between Onset and Death LoyeanS		
8760,	ate be executed hysician end the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):							
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician end 2 shouid be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc	у		23d. Date (
<u>a</u>	uires that signed b	by	Part ii. Other significant conditions combuting to death bar not resulting in the underlying cause given in rare.						23e. Did tobacco use contribute to the cause of deat 1			
Vital Records,	The ate h page	Completed			·			24a. Was auto perfo 1 ☐ Yes	psy price ormed? dea	ere autopsy findings available or to completion of cause of ath?		
	ystcian: s certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/Outpatie	nt 3∐-DOA O#	26. Place of De	ath (Check only		(Specify)		
ion of	Jing After fune								how injury occurred	1		
Division	in Street	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To		or Rural Route Number,		
	To the Hospital within 24 hours a To the Funeral completely filled	edical C			of my knowledge, dea f examination and/or in ated.							
	To th within To th	Me	29b. Signature and tipe of certifier	Der.	1.,	29c. Licens	se number		29d. Date signed (
	10		7	completed cause if c	leat y (Item 23a) (Type	Print)	. 41	illa Ma	July 22,	21093		
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 5 2	67	ar's Signature	andi	urnenu	me ma	- June	21013		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#8 perFh G845,7/25/05 TT State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:15 AM 97 2005 izette Surn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date ver emoria Jinder 1 Year 8. Date of Birth (Month, Day, Year) (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min Days Months Hours 1 M 2021 579-48-25 8 Yrs. Director Romanie Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ral', or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director 1100 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 655 12. Was Decedent Ever in U.S. Armed Forces? 3(deeth v Completed by Funeral d 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after ☐ Yes 2 Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: Specify if Yes, Give Year or Dates: 3 Widowed 4 Divorced "netural', whit th and Mental Hygiene.

7 Is marked other than "netur treumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) L 19 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie ပ enr raulman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I (Good Shypard MD 20736 10augnities 655 JUSAM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dale Department of H Importent: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State -98 Sort 5 Other (Specify) 7OS ° 4 □ Donation remators 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. HA 18434 Approximate Interval Between Onset and Death Immediate Cause (Final disease (or condition resulting in death) CHOLANGIO CARCINO **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 1 Yes 2 Who Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 I No manlia 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 **X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ၉ 1 Yes 2 Z No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural М 1 Tes 2 No deeth. 2 Accident **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours e To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) D 29b. Signature and title of certifier 29c. License number 12005 19427 Azlan Name and address of person who completed cause of death (Items 111111111111 31. Date filed (Month, Day, Year)

JUL 2 5 2005 2. Registrar's Signature State Roser Registrar

			1 - For Stata Registrar	State of M	laryland /		tment o			nd M	_	_	20(15	21.	175	
	Physic /Medi		Decedent's Name (First, Middle, La Me	^{st)} rritt Cha	stain Ba	arton					2. Date of De Month July		y	Year	3. Time o		
	Exami		4a. Facility Name (If not institution, given Shady Grove Adve	ntist Nurs	sing Hom	ie	4b. City, Tow	Ro	ockvi	.11e			. County o		gomer		
	Funeral Director		5. Social Security Number 6. S 453-10-8036 Usual Residence of Decedent	M 2□F	ge (In yrs. last b		If Under 1 Your Months Da	ear	If Under 2 Hours	Min.	8. Date of Bird (Month, Da April	v. Year,	918	9. Birthp Cour	elace (State entry) Texas	or Foreign	
	within 72 hours after death with the Maryland pne. than "naturat," or Items 23a or 28a-f show the Madical Examiner must be natified at	Director	10a. State 10b. County Maryland Mont 10e. Street and Number	gomery	10c. City, To	wn or Loca			ver S	prin						City Limits 2 No	
	be filed within 72 hours after death with the Maryla hal Hygiene. Id other than "natural", or Nems 23a or 28a-f show other than "natural", or Nems 23a or 28a-f show event, the Madical Examiner must be natified at	Funeral Dir	2201 Colst 11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	10f. Zip Coo		2091 panic Orig		cify Yes or No		Uni 14. Race	ted	State	S	
9000	hours after ural', or Ite	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No WWII	10	Yes 2∭X	No	Specify:	Puerto F	Rican, etc.)		Specify:		hite		
Maryland 21215-0036	d within 72 lipene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or		(Give kii life. DC	nt's Usual Oc nd of work do NOT use re County	one dui itired)	ring most		g	16b. K	ind of Busi	ſexa	,	mont	
yland ;	should be filed and Mental Hygic s markad othar umatic event, II	To Be C	17. Father's Name (First, Middle, Last) James		rton		Councy		8. Mother	's Name	(First, Middle,		Sumame)		overm	nent	
e, Mar	d2shi thand thsm ?7ism traum		19a. Informant's Name/Relationship (Joel H. Barton/ S			113	Drisco	11	d Number	or Rural Gai	Route Number	urg,	or Town, Si	ate, Zip ylan	d 208	78	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ 1 □ Cremation 5 □ Other (Specify 21. Signature of Funeral Service Licen	see	Gat	ery, crema e Heave	tory or other en Cem	_{piace)} ete	ry	Ju1y 200		Sil.	ver S hrey	prir	ng, Man	<u>rylan</u> Home/ e	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that cause one cause on each li	d the death. Do	not enter ailur	the mode of	dying,	, Mar such as c	y Lan ardiac or	respiratory an	0-28 rest,	305		Approximat Interval Bet Onset and I 2 Wee	te tween Death	
8760,	cate be executed bhysician and the burial-transit	dical Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence											
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rds, P	w requires that been signed t should be det	b	Part II. Other significant conditions on Coronary Artery D		ut not resulting i	n the unde	erlying cause	given	in Part I.						e cause of d		
Il Records,	The law ate has b page 2 sl	Completed	Atrial Fibrillation Hypertension							performed? death?			r to com th?	sy findings appletion of ca	available ause of		
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ō	ding Phys I. After this funeral dii	tlon: To	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 fnpatie 28a. Date of Inju (Month, Da		Itpatient Time of Injury	28c. Ir	njury at Vork?		28	e 5 Reside			(Specify,)		
Division	0 4 5 5	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined elemined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							If. Location (Si City or Town	treet and n, State	d Number (or Rural	Route Numi	ber,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	one)	vsician: To the best iner: On the basis of and manner sta	examination ar	e, death or	curred at the	time, y opini	date and ion, death	place, an occurred	d due to the call at the time, d	ause(s) ate and	and mann place, and	er as sta I due to	ited. the cause(s))	
•	To To Con	Σ	29b. Signature and title of certifier				29c. Lice D2	ense ni 2865			2	9d. Dat	e signed (A		ay, Year)		
11	rt of		30. N (ess of person who of Ravi Passi, M.D.	ompleted cause of d			nt)			Spr	ing, Ma	ary1		209		r.	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registr	dignature	4	1.1				-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DELIA GOULD DOLL Month July 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | December 8, 1908 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M XXF 218-46-1637 96 Yrs. Director Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits reumetic event, the Mudical Examiner must be notified at XXYes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 611 West University ParkwaY 21210 USA or Items 23e death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 121 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after I ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XX No Completed by X Widowed 4 □ Divorced Specify: neture!' White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) to and 2 should be fill Health and Mental H William Proctor Gould Mary Eliza Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ent: If item 27 is ury or other tree Rebecca Doll Clark Dtr 417 Croydon Road Baltimore, Maryland 21212 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Importent: If eny injury or QDCE. Greenmount Cemetery 7/26/05 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Strone disease or condition resulting in death) weller /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Cause (Cisease or injusthat initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 ☐ Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence Other (Specify) HC5/TCE Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury Hospitel or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N.Charles Street

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUL 2 5 2005

32 Registrar's Signature

Towson, Md. 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of: Death TIMERE Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday Birthplace (State or Foreign **Funeral** 2 🗆 F Yrs. -/2-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location oriant: If itam 27 Is markad other than "natural", or itams 23a or 28a-f ahow injury or other traumatic avant, Ite Medical Examinar must be notified at 10d. Inside City Limits D.C. Director Yes 2 No 10e, Street and Number 10g. Citizen of What Country? U.S.A Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married Yes, Give Year or Dates: 1 ☐ Yes 2 No þ 3 - Widowed Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 Is markad other than "natural", any injury or other traumatic avant, Ita Medical Exa pnres. 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KNOWN 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code 745 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Lo ation - City or Town, State 1 Burial 2 Cremation 3 R 3 Pemoval from State 21. Signature of Foneral Service J. 22. Name and Address of Eacility 23a. Part1. Enter the disease of complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** carcivona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Cissass or inju-that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 PYes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To tha Funeral Director: After this certifics completely filled in by the funeral director.; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OX

State

Registrar

31. Date filed (Month, Day,

JO TISCH

MD

person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

OHN

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			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H			giene Reg. No 2005	21.170
			1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medio		PHILIP A. DUI	VNIGAN				JULY 23		2:45 P. M
	Examir	ner.	4a. Facility Name (If not institution				or Location of Deat	th	4c. County of Death	1
			900 SHEPHARD CO		e (In yrs. last birthday)	BEL A		8. Date of Birth	HARFORD	place (Ctata on Familia
	Funeral Director		216-20-3837 Usual Residence of Decedent	1 1 1 1 1 1 1 1 1 1 1	81 Yrs.	Months Days			r, Year) Coi	place (State or Foreign intry) YLAND
	ow ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man	ţċ	MD N/A		BALTIMOR	E CITY				1 XYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	intry?
	eth w	rail	5603 SAGRA ROAL			21239			USA	
396	be filed within 72 hours after deeth with the Maryland that Hygiene. Id other then "nature!", or iteme 23e or 28e-f show event, the Midfred Examitter has be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ZYes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: WH	
5-0	72 ho	eted	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occup kind of work done	pation during most of wo	ndring	16b. Kind of Business/I	ndustry
Maryland 21215-0036	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire WRIGHT FO	d)	g	STEEL	
d 2	filed with Hygiene. other ther ent, the v		12TH GRADE 17. Father's Name (First, Middle, I	Last)			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
ılan	should be filed within the Mental Hygiene. marked other then matic event, It was	To Be	PHILIP F. DUN	VIGAN			MARIE	A. LOEFF	LER	
lan	S S S	ľ	19a. Informant's Name/Relationsh						r, City or Town, State, Zi	p Code)
	1 and Health Iem 27		JOYCE SCHAEDEL,	DAUGHTER		SHEPHARD	COURT E		MD 21014	
סב	00-		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	_		natory or other pla	7/10		20c. Location - City or T	
Baltimore,			 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I 		DULANEY	VALLEY ME 2. Name an	TATC:		COCKEYSVILL	
Ва	permit. Departmitmports any inju		1				-1.	VD. TOWS	N FUNERAL H ON, MD 212	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that eaused						Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	-a. myel	a consequence of):	sea un	th exc	ess be	lasto	Onset and Death 6 Minutes
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	n and	Exan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);					
8760,	icate be execute physicien and s the burial-trans	dicail		d						
9	ntifica ng phy as th	a a	IF FEMALE:							
O. Box	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of deliv Month	ery Day Year
rds, P.	quires that en signed b uld be deta	þ	Part II. Other significant conditio	ns contributing to death b	ut not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	bacco use contribute to	he cause of death? bably 4 □Unknown
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Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth	OF	ath (Check only on	DAUGHTE	R'S
of	Phys or this oral di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		1 3 DOX	4 Nulsing i	lome 5 Reside	ance 6 x Other (Speci ow injury occurred	RESIDENCE
ion	Attending In death.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investig		y Year) Injury	Wor	k? Yes 2⊡No			
Division	el or Attendin safter death. I Director: Af d in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,
	Hospite 4 hours Funere iely fille	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical B	Physician: To the best examiner: On the basis of and manner sta	r examination and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	and due to the caurred at the time, da	ause(s) and manner as sate and place, and due t	stated. the cause(s)
	To the within 2 To the complet	M	/29b. Signature and title of certifier	01	0	29c. Licens		25	9d. Date signed (Month,	
)	a W	/	Lavre	ne / An	dernh	The second second	30127		7-25-0	5
1	(U/		30. Name and address of person v	who completed cause of d	eath (Item 23a) (Type,	Print) LAWRE	ENCE J. S	SNYDER, M	D	
	Sta	te	7505 Ugler D 31. Date filed (Month, Day, Year)	32. Registe	r's Signature	on in	a, 21	207		
	Registr		JUL	2 5 2005	men &	(Specific)				

			FOR	State of Maryland				Mental Hyg	iene 200	F 01		
		_	- State Registrar AMEND ITEM	10b-f PER FH	G8 Çert	ificate of	Ge ath		eg. No. 200	C - 7		
	Physicia	an	1. Decedent's Name (First, Middle, Last) Joseph Frede	erick Fre	.v			2. Date of Deat Month JULY	Dey Year	1.4		
4	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o	Location of Deat	1	4c. County of De			
	LXammi	Ç,	Saint Joseph M	edical Cent	er.		Tows			timore		
	Funeral Director		5. Social Security Number 6. Sex 13-18-1570	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		Year) (irthplace (State or Foreign Country) Maryland		
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits		
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	th the or 28a e routi	Director	10e. Street and Number 2808 KINC	SS RIDGE RD.A	РТ С	10f. Zip Code		1	0g. Citizen of What (Country?		
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2-0036	2 hour	ted t	15. Decedent's Educa	ition	16a. Decede	int's Usual Occup	ation		16b. Kind of Busines	s/Industry		
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and	e d ta b	To Be	Frederick	G. Frey			Marga			aumer		
Mary	d 2 should th and Men 7 Is marke treumatic	۲	19a. Informant's Name/Relationship (Type	e, Print), Sister		,			, City or Town, State	Zip Code)		
	s 1 and 2 f Health a item 27 ls other tre		Mrs. Bernadette Her			akin Cou		imore, MD		-		
ore	it of H it of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		ition (Name of atory or other place			20c. Location - City o			
altımore,	permit. Pages Department of Important: If is any injury or once.		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licenses		oly Red			15/05	Baltimore Maryland			
Ba	permit. Departi Import any inj		+ faul I Hair	tark - Je					Hartord			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that cruse the death cause on each line.	n. Do not enter	r the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death		
ļ	Physician		Immediate Cause (Final disease or condition resulting in death) ABDOMINAL AORTIC ANEURYSM RUPTURE Due to (or as a consequence of): CHRONIC RENAL FAILURE									
	/Medical Examiner											
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ŏ	death certificate be executed e attending physician and nd for use as the burial-transi	Physician/Me	23b. was decedent pregnant	c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy	,		23d. Date of d	elivery Day Year		
O. B	ne dea the att	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 🗖	Other (specify)			Wishtan	Day Foul		
ď.	that the de led by the a detached	y Ph	Part II. Other significant conditions conti	ributing to death but not resi	ulting in the und	derlying cause giv	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?		
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ita		Be C	25. Was case referred to medical				26. Place of De	ath (Check only on	/	24,110		
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uc	ding P. After funera	tion:	27. Manner of Peath Natural 5 Pending Natural investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ⊡No	28d. Describe no	ow injury occurred			
Division of	or Attenditter death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre			28f. Location (Si City or Town	reet and Number or and State)	Rural Route Number,		
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely illied in by the funeral director,	Medical Ce		cien: To the best of my kno er: On the basis of examina and manner stated.								
	o the ithin 2 o the omptel	Med	29b. Signature and the of certifier	and mailler S(8180.		29c. Licens	e number	2	9d. Date signed (Mo	nth, Dey, Year)		
)	7) Man	かいかい		D 20	103607	7	122/05			
	0		30. Name and address of person who con	pleted cause of death (Item	23a) (Type, P							
/			31. Date filed (Month, Day, Year)	7671 C 32. Registrar's Signa		DRIVE	OWSON I	MARYLAN	21204			
	Sta Regist		.111 2 5 2			Cook						

		•	For State Registrar	State of	f Marylan		artment <i>rtificate</i>			nd M	ental Hy	giene Reg. No	000	15	21.180
			Decedent's Name (First, Middle, I	Last)							2. Date of De			rear	3. Time of Death
	Physici /Medic		LOUIS AUGUST G	ASSINGER							July	21		05	11:45 a.™
	Examin		4a. Facility Name (If not institution, g				,		Location of	Death			. County of	Death	
			Good Samaritan N			E - a filiate di il	Ba If Under 1	ltim	ore	4 Hre	0 D (D.		n/a	District	(Ch. h
	Funeral Director		5. Social Security Number 216-16-3171	i. Sex 1☐ M 2☐ F	7. Age (In yrs. 84	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, Day)	y, Year) 192		Coun	lace (State or Foreign try) Land
			Usual Residence of Decedent	Λ				1			Nov.	عر ـــ و	.0 1	rai y	rand
	nyland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	Od. Inside City Limits
	a Ma Ba-f s	Directo	Maryland Baltim	ore	To	wson									1 ☐ Yes 2 ☐ No
	vith th	Dire	10e. Street and Number	4-1-200	,		10f. Zip (_			-	izen of Wh	at Coun	try?
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36	n 72 hours after death with tha Manylan "natural", or Items 23a or 28a-f show officel Examilier and be notified at	by Funerai	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For	rces? 2 □ No WW e	11	fYes, speci 1 ☐ Yes 2		Specify:	Puerto	ecify Yes or Ne Rican, etc.)		Black,	White, whi	etc.
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7	ba filed within 72 hc tal Hygiene. d other than "natun event, It e III allen	Completed	(Specify only highest : Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	e retired)	uning most	OF WORK	ng .				0
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and	ba fil	Be	17. Father's Name (First, Middle, La	ist)) <i></i>					(First, Middle	, Maiden	Sumame)		1
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Mar	12 s h ar 7 ls trau		Doris M. Gassing)		corn (202 To				· ·
ē,	- I 5 =		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer				100	ate		ocation - C		
Ē			1 🛱 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State	ulaney				s.7/	25/05	Time	onium	.Mar	yland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee		22					d F.H. Baltim				
10	7		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplication at ca	aused the deat	th. Do not ent	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,	LLYL	aria	Approximate Interval Between
	Physician		Immediate Cause (Final		Fibri.									N	Onset and Death
	/Medical		disease or condition resulting in death)	a	oras a conseq		.1								Months
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C. BOX	at the death certificate be exacuted by the attending physician and tachad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d	I death 3	Ectopic pre Other (spe						23d. Date Month		ry Day Year
ŗ.	that the bound of the by	by Ph	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco u	use contrib	ute to th	e cause of death?
cords	w requires that been signed b should be deta										10	Yes 2	□No 3	☐ Proba	abiy 4 Kunknown
T T	a ta has ye 2	Completed									24a. Was auto perfe		pride	or to con ath?	osy findings available apletion of cause of
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010	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 📉 No			ER/Outpatier		-	4 X INUI	Control or property	ne 5□Res)
	ding P h. After t tunera	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury		lc. Injury Work	?		28d. Describe	how injur	ry occurred		
Mision	or Attending ifter death. Diractor: After in by the fune	icati	2 Accident investiga 3 Suicide 6 Could no	t be	of Injury - At he	oma farm et	M act factors		es 2 □ N		28f Location	Street an	nd Number	or Rum	Route Number,
\leq	al or Attend after death Diractor: A	Certification;	4 Homicide determin		ng, etc. (Specif		eel, lactory,	Office			City or To			or ridia.	rioute rumber,
	Hospita 4 hours Funera ely fille	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the caminer: On the ba	isis of examina	owledge, death	occurred a	t the time in my op	e, date and inion, death	l place, a	and due to the ed at the time,	cause(s) date and	and mann d place, and	er as sta d due to	ated the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	Tank	alec	æeu	29c.	License	number 30 6	61		29d. Dat	te signed (Month, L	Day, Year)
k	1		30. Name and address of person wh	ho completed caus	e of death (Iten	n 23a) (Type,	Print)								
1	1		Sireesh Tripura	neni 5/	CO1 LOC	h Rave	n Blv	d. E	Balto.	Md	21230)			
	Sta	- 30	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ature	<i>M</i> .								
L	Registr	ar	JUL 2 5 20	U5 Alles	5 JS	10,000									

			1 - For State Registrer	State of Maryland		nent of H		,	•	_
	Physici		1. Decedent's Name (First, Middle, Last) ERNESTIA	10		Hyde		2. Date of De	Day	Year 7 3. Turner of Death
	/Medic Examir		4a. Facility Name (If not institution, give s. 4533 DQIIAS 5. Social Security Number 6. Sex	place # 10	3 7		r Location of Deat	S	23,200 4c. County of Prince	Death Ce Georges
	Funeral Director		,	M 298F 57		onths Days	Hours Min.		y, Year)	9. Birthplace (State or Foreign Country) VITTINIC 10d. Inside City Limits
	n the Man r 28a-f sh	Director	Maryland Prince 10e. Street and Number	Georges T	emple	E HI Of. Zip Code	ils		10g. Citizen of Wh	1 Yes 2 No
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic avant, Ite Medical Examiner must be mutilised at	by Funeral D		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:		207 Decedent of H is, specify Cuba (es 2 No	ispanic Origin? (S in, Mexican, Puer	pecify Yes or No to Rican, etc.)	14. Race -	•
Maryland 21215-0036	e filed within 72 hou al Hygiene. I other than "naturs vant, Ir e Modical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent' (Give kind life. DO I	of work done o IOT use retired	during most of wor	ider	16b. Kind of Busi	Home
yland	should be fi ind Mental H s marked ott umatic avar	To Be	17. Father's Name (First, Middle, Last) Pleasan+	Hyde			Anna	a	Maiden Sumame)	iell
Baltimore, Mai	Pages 1 and 2 st nent of Health and int: If Itam 27 is n iry or other traun		19a. Informant's Name/Relationship (Typ Tawes Hyde - 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	- SeA 20b. Plac	5205 be of Disposition etery, cremator	(Name of y or other place	e + + +	ST OX	20c. Location - Cl	l md 20745 Ity or Town, State
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	Pnysician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Mulattat Due to (or as a consequer	رز لا			-		Approximate Interval Between Onset and Death
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rds, P	quires that n signed b	d by P	Part II. Other significant conditions control	ributing to death but not resulting	ng in the underl	ring cause give	on in Part I.			ute to the cause of death?
al Records,	ilcian: The law requir certificate has been si rector, page 2 should	Completed						24a. Was a autop perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 \sum No
Division of Vital	ding Phya n. After this funeral dii	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		VOutpatient 3/8b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing H			(Specify)
Divis	tal or Attands safter death	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, f	actory, office		28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,
	To tha Hospital or I within 24 hours after To tha Funaral Dira completely filled in b	edicai	29a. Certifier (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occi and/or investig	arred at the time ation, in my op	e, date and place inion, death occur	, and due to the c rred at the time, o	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
L	To tha within 2 To tha complei	N	29b. Signature and title of certifier 30. Name and address of person who com	inpleted cause of death (Item 23	3a) (Type, Print)	29c. License			29d. Date signed (A	
	Sta Registra		Shadi HAM) 31. Date filed (Month, Day, Year) JUL 2 5 200	32. Finistrar's Signature	66 IR	wing:	57, N, W	14218	WAShir	20010 20010 1370m, 19.C.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 4a. Facility Name (If not institution, give street and number) Roduev 21 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Bayview Modical Contr Hopkins If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Days Hours 220-30-0380 1 M 2 □ F Yrs. MARY/AND MAY 27, 1934 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Menta! Hygiene ortent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show injury or other treumatic event, the Medical Exact artment by natified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director MARYING 10e. Street and Number)UNDALK Altimore 10f. Zip Code 10g. Citizen of What Country? 3413 Loux OAT 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steelworker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဥ unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3413 AZK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. CREMATERY JULY 25, 05 Other (Specify) View 4 Donation 22. Name and Address of Facility 21. Signature of Tuperal Service Licensee Morticum a, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list grily one cause on each line. BALLIMERE 1203 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Congestive Failure Heart **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐Unknown 1 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣No 24a. Was an autopsy 2 No this certificate 1 Yes To the Hospitei or Attending Physicien: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: <u>L</u> 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Director: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 / Homicide within 24 hours a tale Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2005 AF-2664200-E337 and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 4940 Eastern A. Eckman MD John Avenue 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUL 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year John H. Heuer /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b_City, Town, or Location of Death 4c_County of Death Franklin Square Center HOSP tas Kosedale Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/29/1920 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Days M 2□ F Months Hours Min 85 218-07-6096 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County or 28e-f show 10d. Inside City Limits traumatic avent, the Medical Examiner must be notified at MD Baltimore Director Baltimore 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. Apt 3306 or items 23a 21234 Funerai U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🗝 No þ Specify: Specify: White 3 Widowed 4 Divorced "netural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Estimator A.A.I. Corppostion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otho S. Heuer Anna Bruning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra Mary Heuer/Wife 8820 Walther Blvd. Apt. 3306 Balto. MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Balto./Wash. Crem. * 4 ☐ Donation 5 ☐ Other (Specify) 7/27/05 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, be leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heart Ische Mic /Medical Due to (or as a consequence of): Examiner Atheroscler OSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be execut resulting in death) Last Due to (or as a consequence of): burial-Box 68760, nding physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Por Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9☐ Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cate has been signated by page 2 should b 2 No 3 Probably 4 Unknown Completed 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 2 2 No 1 Yes Hospital or Attanding Physician: Be (funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 3 100 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medicai completely (Check only one) To the 29b. Signature and title of certifier 30. Name and address of p death (Item ac alantag 32' Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 5 2005 Registrar

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			1 - For State Registrar	State of	Marylan		artmen rtificat					_	200) [01.101
			Decedent's Name (First, Middle, Last	(t)	-		· · · · · · · · · · · · · · · · · · ·	0 07 1	Joann		2. Date of De		200	10	3. Time of Death
	Physici /Medi		Iola Mary Hall								July 21	1. Day	005	/ear	6:09P M
	Examir		4a. Facility Name (If not institution, give	street and num	nber)		4b. City,	Town, or	Location of				County of	Death	
			Manor Care-Potom	ac			Pot	omac				Mo	ontgo	mery	7
	Funeral		5. Social Security Number 6. S	ex □M 2XIF	7. Age (In yrs. h		If Under Months	1 Year Days	If Under	Min.	8. Date of Bir (Month, Da	th ay, Year)		9. Birthp	lace (State or Foreign
	Director		213-56-9481 Usual Residence of Decedent		8	7 Yrs.					July 1	6, 1	918 (Cana	ďa
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	Man Pefsh	tor	Maryland Montgom	erv	De	rwood									1 ☐ Yes 2 → No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of Wh	at Coun	try?
	15 will		6712 Glen Oak Cou	rt			208	355				Cana	ada		
	within 72 hours after death with the Maryland ene. then "neturet", or items 23s or 28e-f show he Medical Eva nicer must be rediffed at	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S ces?	S. 13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No Rican, etc.))-	14. Race -	Americ White,	
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Ş	hour	ed b	15. Decedent's Ed		ites:	16a. Deced	iont's Heur	I Occupa	tion	-		100		Whi	
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멀	be filed within 72 hours after death with the Marylan ital Hygiene. od other then "neturel", or items 23s or 28e-f show svent, the Medical Exacticer must be redified at	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,				
<u> a</u>	Ments Ments Mrked	10	James H. McDonell						Lou	ise I	Legris				
lar	2 should be and Mental Is marked of reumatic sv		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rurai	Route Number	er, City o	r Town, St	ate, Zip	Code)
رب ح	and lealth m 27 her tr		Donna Duce/Daught	er	201 51						erwood,		-		.0855
Baltimore, Maryland 21215-0036	ges it of H		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from S	itate Mon	metery, cren	sition (Nam natory or ot	ne of ther place	9)	July	23.	20c. Lo	cation - Ci	ty or To	wn, State
計	it. Pa ritmer ritent: njury		`4 □Donation 5 □Other (Specify		Cre	matori	remaiory or other place) ery July 23, ery rium, Inc. 2005 Bethe 22. Name and Address of Facility Robert A. Pumpl Rockville, Inc. 300 West Montgo						iesda	, Ma	ryland ,
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic ssone.		21. Signatural al Service Licen	500 2000-	, моов	$03 \begin{vmatrix} R_0^{22} \\ R_0 \\ R_0 \end{vmatrix}$	Name and Ckvil	d Addres Lle, lle.	Inc. Marv	300 300	West M 20850	Pump lonts 280	onrey gomer 15	y Av	enue
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	Priysician		Immediate Cause (Final disease or condition	con	GEST	SVE	HE	DR	7 1	1021	leire				Onset and Death
	/Medical Examiner		resulting in death)	Cause (Final condition death) a. CONCESTIVE HEART + Ceilere. Due to (or as a consequence of):											
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	ficate be executed physician and is the burial-transit	xan	that initiated events resulting in death) Last	c	r as a conseque	ence of):								-	
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Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								2	3d. Date o	of deliver	v
m.	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna	th 2 Fetal on that time of dea		Ectopic pre Other (spe						Month		Day Year
P.O.	that the de ed by the a detached f	hys	9 Unknown	9□ Unknov											
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ord	w require been sig		1) emention								1 🗆 Y	′es 2□]No 3[] Proba	bly 4 Dinknown
Records,	has be	Completed									24a. Was a		24b. Wer	re autop	sy findings available
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	운 등 등	2	1 Yes 2 No 27. Manner of Death			R/Outpatient			42 Nur		9 5 ☐ Resid			Specify)	
Division of	ding h. After fune	tion	1 Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury	M	lc. Injury Work	at ? es 2 □ N		d. Describe h	iow injury	occurred		
18	Atten deat ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place o	f Injury - At hon	ne. farm. stre			63 2 114		If Location /S	treet and	Number	r Rumi	Route Number,
S	al or after	erti	4 Homicide determined	building	g, etc. (Specify)						City or Tow	n, State)	110/110/01	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	riodie redriber,
	To the Hospitel or Attending Phyelcien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sicien: To the b	est of my know	ledge, death	occurred a	t the time	e, date and	place, an	d due to the d	ause(s)	and manne	er as sta	ted.
	he Hi in 24 he Fu pletel	Medical	(Check only 2 Medical Exeminate)	ner: On the bas and manne	is or examination	on and/or invi	estigation, i	in my opi	nion, death	occurred	at the time, o	date and	place, and	due to t	he cause(s)
	To t Withi To tl	Σ	29b. Signature and title of certifier	~			j ,	License		16	2	29d. Date	signed (N	fonth, D	ay, Year)
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P	10		30. Name and address of perso who co	ompleted cause	of death (Item 2	23а) (Туре, Р	rint)								
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	Physici /Medic		Decedent's Name (First, Middle, Last) SIGMUND			HOLTZMAN		2. Date of De.	ath 40	271100 of De 5 5:45 A M		
	Examir		4a. Facility Name (If not institution, give str NORTH OAKS HEALTH			4b. City, Town, or PIKESVIL	Location of Deat	h	4c. County of BALTIMO			
	Funeral Director		EIG IE EGES X		92 Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt Month, Da NOV . 1	y 1912	Birthplace (State or Foreign Country)		
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits		
	the Ma 28a-f s	ecto	MD BALTIMORE 10e. Street and Number		BALT	7		***		1 ☐ Yes 2☐ No		
	h with	al Dir	725 MT. WILSON LAI	NE APT. #4	-28	10f. Zip Code 21208			10g. Citizen of Wha	•		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "naturel; or items 23s or 28a-f show other treumetic event, the Medical Evarinet must be rediffied at	by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Eve. Armed Forces? 1 Tyes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H. f Yes, specify Cuba I □ Yes 2 No		pecify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc. WHITE		
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	e filed al Hygid other vent,	Be Co	17. Father's Name (First, Middle, Last)		MANAGI	-K	18. Mother's Nar		LEON LEV] Maiden Sumame)	I INC.		
Maryland	should be nd Mental marked o	To	JACOB		HOLTZMA		TILLIE			NGER		
	ss 1 and 2 sh of Health and item 27 is n r other treun		19a. Informant's Name/Relationship (Type RUTH HOLTZMAN / WIF	E	725	MT. WILSO		APT. #42		RE, MD 21208		
altimore,	Page ent c ent c rt: If ry or		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	ANSTHE OF DISPOSED ANSTHE OF EMU AITZ CHAI	MAH ^{r other place} M	107/2	2/2005	BALTIMORE	E. MD.		
Ba	permit. I Departm Importar any injur		21. Signature of Funeral Service Licensee	7	> 89	900 REIST	ERSTOWN	L LEVINS ROAD - P	ON & BROS IKESVILL	S., INC. E, MD 21208		
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	death. Do not ente		g, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death		
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8760,	cate phy:	dical	d		riabetes 1	nellitus						
O. Box 6	at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of prince	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
ds, P	signed d be de	by	Part II. Other significant conditions contril	outing to death but no	t resulting in the un	derlying cause give	n in Part I.			e to the cause of d - th? Probably 4 2 nknown		
Records,	e law has b	ompleted						24a. Was a autops perform	ned? 🦯 deatl			
Vital	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dear	th (Check only on		Yes 2□ No		
_	ding Phys h. After this funeral di	္ရ	1 Yes 2 No Hos	pital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at		ince 6 Other (S	Specify)		
UIVISION	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Certification:	3 □ Suicide 6 □ Could not be □	28e. Place of Injury - building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number or , State)	Rural Route Number,		
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier (Check only one)	an: To the best of my : On the basis of exam and manner stated.	knowledge, death mination and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)		
	To To com	Σ	29b. Signature and title of certifier			29c. License	number 57465		9d. Date signed (Mo			
1	7		30. Name and address of person who comp	leted cause of death	(Item 23a) (Type, F	brine)			7/2	1/05		
U	Sta	0	N.S. KajagaksemD 31. Date filed (Month, Day, Year)	7220 Park 32. Redistrar's S	Heights A	v. Baltimo	me MID	21208				
	Registra	_	JUL 2 5 201)5 Magaag	15 19	THE PARTY OF THE P						

יכ	Please	Type or Prin	t in Blac	k Ind	lelible Ink	Ensu	ıre All	Copies	Are l	Legible	e.		
	Amend Item 1	L&State_of_Ma	ryland / [Эера	rtment of h	lealth :	and Me	ental Hyg	iene				
	Amend Item 1 1- State Unpend Item	23a,27,28a	-r per	Cert	tificate of	Death	as	P	eg. No.	200		21 10	_
	1. Decedent's Name (First, Middle, La	st)					2	2. Date of Dea Month	th Day		ar	Tiffle of Death	0
n	Jered Paul Harris	on						July 21	-	005 "	di	8:23 p.	М
r	4a. Facility Name (If not institution, give				4b. City, Town, c			,		County of D			
2	Howard County Ger	neral Hospi	tal		Co1	umbia]	Howard	d Cou	ınty	
	5. Social Security Number 6. S		(In yrs. last bit		If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birtl (Month, Day	Year)		Birthplac	e (State or Fore	ign
	212-15-2623	1(3 tM 2□F	26	Yrs.	Monard Bayo		I	1ar 30	1979) Ma			
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation						10d	foside City Limi	te
_			Woodbi										
Directo	MD Carroll		WOOdbi		104 7in Code				Om Citi	zon of Wha	t Country	2	_
בַ	10e. Street and Number				10f. Zip Code								
ē	2119 Gillis Falls			42.14	21797 /as Decedent of F	Vinnania On	inin? (Casa						
runerai	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N		13. W	Yes, specify Cub	an, Mexica	n, Puerto Ri	ican, etc.)		Black, V	White, etc		
	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	0	1	☐ Yes 2X No	Specify	:			Specify:	White	е	
9	15. Decedent's E		16a	. Decede	ent's Usual Occur	ation	-		16b. Kir	nd of Busin	ess/Indus	stry	
plet	(Specify only highest gra	ade completed)		(Give k	and of work done ONOT use retire	during mos d)	st of working	7					
Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	_	rmer	•				Agri	icultu	ıre		
e C	17. Father's Name (First, Middle, Last,	1)				18. Moth	er's Name (First, Middle,	Maiden	Sumame)			
0	Jeffrey L. Harris	on				Sue A	Ann Co	nstant	ine				
	19a. Informant's Name/Relationship ((Type, Print)	191	o. Mailing	g Address (Street	and Numb	er or Rural	Route Numbe	r, City o	r Town, Sta	te, Zip Co	ode)	
	Jeffrey L. Harris	on	21	19 G	Gillis Fa	alls 1	Rd. Wo	odbine	, MI	2179	7		
	20a. Method of Disposition	7	20b. Place o	of Dispos	ition (Name of atory or other pla	ce)	Da	te	20c. Lo	cation - City	y or Town	, State	
	1 ☑ Buriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				pel Cem.		25/20	05	lood	bine,	MD		
	21. Signature of Funeral Service Lice	nsee 77		22.	Name and Addre	ss of Facil	ity					D 4	
	A Totally. he	ellen		Bur 121	rier-Que 2 W. 016	en Fi	uneral ertv F	L Home Rd. Win	and fiel	crema ld. MI	10ry	7, P.A. 184	
	28a. Part 1. Enter the disease, or com	nplications that caused	the death. Do	not ente	r the mode of dyi	ng, such as	cardiac or	respiratory ar	est,		A	pproximate	
	shock, or heart failure. List only Immediate Cause (Final												
	disease or condition resulting in death)	a. Electroc	a consequence	of):							-		
			,	,-									
e	Sequentially fist conditions, if any, leading to immediate	b. Due to (or as a	a consequence	of):									
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	6											
EXB	resulting in death) Last	Due to (or as a	a consequence	of):									
Ca		d											
ledica									- 1	·			_
5	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth		n 3□	Ectopic pregnanc	v			2		-		
CIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□ Pregnant at 9□ Unknown			Other (specify) _	-			9. Birthplace (State or Foreign Country) 1979 Maryland 10d. finside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Agriculture Maiden Sumame) Tine 16c. City or Town, State, Zip Code) 2. MD 21797 20c. Location - City or Town, State Woodbine, MD and Crematory, P.A. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year				
Pnysician/M	9 Unknown	3LI OHKHOWN											
Š	Part II. Other significant conditions	contributing to death bu	ut not resulting i	in the un	derlying cause gr	en in Part	l.		1				
								1 🗆 Y	es 2	No 3[] Probab	fy 4 □Unkno	ΝΠ
ple								24a. Was autop		24b. Wer	e autops	y findings availal fetion of cause of	ole
Completed								perfor	med? 2 \Begin{array}{c} No	dea	prior to completion of cause of death? 1		
ø	25. Was case referred to medical					26. Plac	e of Death	(Check only o					_
o	examiner? 1 ∰ Yes 2 ☐ No	Hospital:	nt 2 🖳 ER/O	utpatient	3□ DOA Ot	200		e 5 🗆 Resid		6 Other (Specity)		

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 should be within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2

Physician /Medical Examiner

> 1 X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

7:23 21-05 Рм

28b. Time of

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

subject electrocuted

28d. Describe how in ury occurred

28f. Location (Street and Number or Bural Route Number, City or Town, State) 975 McKendree Road West Friendship, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 □ No

28c. fnjury at Work?

29c. License number OCME

farm

29d. Date signed (Month, Day, Year) July 22,2005

of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Tasha

State Registrar

Medical Certification:

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier (Check only one)

2005

amend item#19a, per Inf. G845, 7/26/05 IT State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month July Virginia Ruth Jeffrev 9AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 518 Stevenson Lane Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)
November 26, 1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M XXF 075-07-4371 90 Yrs Director New York Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Directo Maryland Baltimore 1 ☐ Yes XX No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 518 Stevenson Lane 21286 or Items 23a USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (Cholo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 12 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XeXXNo ρ Specify: White 3 Widowed 4 Divorced Specify Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Coleman Babcock Ada May Luther Pages 1 and 2 should 19a. Gorgan's Name/Relationship (Type, Print)
Sallie A Stauffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is y or other trai Dtr 5311 Winding River Road Richmond Texas 77469 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 remation 3 ☐ Removal from State Department o Important: If any injury or once. Greenmount Cemetery 7/26/05 41 Donation 5 ☐ Other (Specify) Baltimore, Maryland gnature of Funeral Ser 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 4 (/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 No 3 Probably 4 □Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 PNatural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 5 2005

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Mental I 1- State Amend Items 4c,25,27,28d per Amend 7/11/05dhb	Hygiene 2005 24 88
	Physic			Day Year
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of	Baltimore Birth Pay Yearl 9. Birthplace (State or Foreign
	Director		213-16-5953 1 M 2 F 88 Yrs. Months Days Hours Min. (Month) Usual Residence of Decedent	Day Year) 18/1917 MARYLAND
	ith the Maryland or 28e-f show	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	vith the M	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	er death v Items 236	Funerai	3712 MARY AVENUE 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or	U.S.A. 14. Race - American Indian,
5-0036	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or Items 23e or 28e-f show ant, the Medical Examitter must be modified at	by	a 3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:	Black, White, etc. Specify: BLACK
5-0	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
2121	be filed within tal Hygiene. Id other then svent, the W	Completed	Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE	HEACTHCARE
Maryland	be de la se	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mid	
Mary	12 should h and Mer 7 Is marke treumetic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe	mber, City or Town, State, Zip Code)
_	of Healt of Healt I Item 2	11 0	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
altimore,	Page ent nt: i		4 Donation 5 Other (Specify) Green Mount Crematory 6 27 2005	BALTIMORE, MD
Ball	permit. Pa Departmen Importent: eny injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremati 5151 BATIMORE NAT'L	on Services, P.A. Pike BALTOIND 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.	y arrest, Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Persistent vegetative state Due to (or as a consequence of):	1 1 1 1 1 1 1 1 1 1 2 2 2 2 3
\	Examiner		Sequentially list conditions, if any, leading to infiningulate b. Acute Stroke - post-operate Due to (or as a consequence of).	PROPERTY EXAMPLE (U-ECKS
2/	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PANEL STEWNER
50,	be executed sician and burial-transit		that initiated events resulting in death) Last Due to (or as a consequence of):	
2 <i>K</i> 7	ficate b physic s the b	edicai		
Box	tth certific tending p or use as t	an/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
P.0.	Attending Physicien: The law requires that the death certificate be recath. r death. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	hysicia	4 Pregnant at time of death 5 □ Other (specify)	Month Day Year
S,	res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	id tobacco use contribute to the cause of death?
150	w requir been si should			☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
of Vital Record	The law sate has I page 2 s	ompieted	24a. W ai	utopsy prior to completion of cause of death?
/ital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner? 26. Place of Death (Check on	
of	Physi r this c sral dire	7: To	The state of the s	esidence 6 S Other (Specify)
sion	itending Ph death. tor: After th the funeral	ation	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Descrit Injury A M 1 Yes 2 No Subjection	ect fell
Division	P F F C	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	n (Street and Number or Rural Route Number, Town, State)
	Fur 4 h	edical C	Hemosi Like Home Mass sita Living Fracility TXXX M	Manne Avenue Pal to Md 2/207 he cause(s) and manner as stated. he, date and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
7			MAnthy Kely, mp 025205	June 21, 2005
~	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). W. A. R. (By G. BMC 670) N. Charles St. Backto and E	2(20k
	Sta Registr	- 42	31. Date filed (Month, Day, Year) 5 32. Registrar's Signature	
			7	

			1 - For State Registrar	State of		d / Depa		t of H	ealth a		ntal Hygi	ene g. No. 20		21.100
	Physic /Medi		Decedent's Name (First, Midd JOHN	lle, Last) JOHN	SON						Date of Death Month	Day	Yeer	3. Time of Death
}	Exami		4a. Facility Name (If not institution	n, give street and numb	oer)		4b. City,	Town, or	Location of			4c. County		
			UNION MEMORIAL 5. Social Security Number	6. Sex 7	A=0 //= .uro	land brings of a 1	If Under		IMORE		(0)	N	/A	
	Funeral Director		214-68-3336 Usual Residence of Decedent	6. SeX M 2□F	Age (In yrs. 1	Yrs.	Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y 7, 19		9. Birthp	lace (State or Foreign try) MD
	/land		10a. State 10b. County	,	10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Man a-f sh ified	tor	MD	N/A		BALT	IMORE							1XXYes 2 ☐ No
	or 28	Olrec	10e. Street and Number				10f. Zip	Code			10	g. Citizen of W	hat Cour	itry?
	ath w	rall	5207 YORK ROAI					1212				USA		
336	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show the Medical Evanture from the rotified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mai 3 □ Widowed 4 □ Divorce	If Yes Give	es? XINo		Vas Decede f Yes, spec I □ Yes 2		spanic Orig , Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	Black	Americ c, White,	
9	'2 hou	ted	15. Deceder	nt's Education		16a. Deced	lent's Usua	Occupat	tion		1:	6b. Kind of Bus	siness/Ind	dustry
2121	J within 7 jiene. r than "n the Med	omple	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of word DO NOT usi A DO			of working		Cons		_
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exama matter footified at once.	To Be C	17. Father's Name (First, Middle, JOHN JOHNSON	Last)							rst, Middle, Mi	aiden Sumame	e)	
	alth and I		19a. Informant's Name/Relations DARLENE JOHNSON									City or Town, S		Code)
Baltimore,	Pages 1 a ent of He nt: If Item ry or othe		20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (5		ate C	lace of Dispo emetery, cren ZION	sition (Nam natory or oti	e of her place		Date,		Oc. Location - C		
Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service	-	200	22	Name and		of Facility	JAME	ES A. M		SO1	NS FH, IN
3760,	Associated and hybridistransit he burial-transit he burial-transit he burial-transit he burial-transit here.	23a. Pár. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, large, large to the mode of dying, such as cardiac or respiratory arrest, and											Approximate Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be defached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal It at time of de	death 3 🗌	Ectopic pre Other (spe					23d. Date Mont		ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditi	ons contributing to deat	h but not resu	ılting in the ur	derlying ca	use given	in Part I.				oute to the	e cause of death?
al Records,		Completed						•			24a. Was an autopsy performe 1 Yes 2	pri pd? de	or to com	sy findings available of cause of
Division of Vital	Jing Ph After th funeral	ertification; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendir investi 2 Accident investi 3 Suicide 6 Could determ	Hospital: Inp 28a. Date of (Month, gation notice 28e. Place of	njury Day Year) Injury - At ho	EP/Outpatient 28b. Time of Injury me, farm, stre	28 M	c. Injury a Work?	4 □ Nurs	sing Home 28d.	Describe how ocation (Stre	ce 6 Other injury occurred	d	Route Number,
۵	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	O		ng Physician: To the be	etc. (Specify		occurred a	t the time	data and		City or Town, :			tod
	the Hos	Medical	(Check only 2 Medical one) 29b. Signature and file of perific	and manner	s ot examinati	ion and/or inv	estigation, i	n my opir	nion, death	occurred at	the time, date	and place, an	d due to	the cause(s)
	7 × × × ×		Day and the state of the state	1 m	\supset		- 1	License r	2	3946		Date signed		*
3	1		30. Name and address of ge son	who completed cause of ML	of death (Item	23a) (Type, F 201 E	Print)	ersit	0	- kwas	Bult.	more, M	10	21218
	Sta Registr	_	31. Date filed (Month, Day, Year)	AT .	istrar's Signati	ure .		l		0	V			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death [□]2005 **Physician** July Edward Danie1 24. 11:00 A.M Kowalewski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 8. Date of Birth (Month, Day, Year) 1926 November 20, 1926 Maryland **Funeral** Months 219-18-6626 **1**XXM 2□ F 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Mudical Examiner must be notified at Director Mary land Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Boulevard Apt. 2201 21234 USA items 23e Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Postman U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kowalewski Josephine Grzybowski ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other treu once. Amelia Kowalewski/Wife 8810 Walther Boulevard Apt. 2201 Parkville MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 7/27/05 St. Stanislaus Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Dundalk Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton hustra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanced Dementio /Medical Due to (or as a consequence of): Examiner disease COFONOLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Dichetes and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth ∠ ☐ r o.c. 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Arkinown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation М 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ona) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) vano, - mer D58676 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard 8800 monia 31. Date filed (Month, Day, Year) 32. Digistrar's Signature State 2 5 2005 Registrar

owalewski

			1 - For Stata Registrar	State of Maryl	and / Depa	artment of H	ealth and M	lental Hygi	ene g. No. 20 (
	Physici /Medi	al	Decedent's Name (First, Middle, Last) Langford			Kidd		2. Date of Death Month July 1	9 200 ⁵	6:38 P M
	Examir Funeral	er	4a. Facility Name (If not institution, give s Union Memorial Hos 5. Social Security Number 6. Security Numb	pital 7. Age (In)	rrs. last birthday)	Baltimo	TE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9	Death N/A Birthplace (State or Foreign Country)
	Director		215-82-7678 1D Usual Residence of Decedent 10a. State 10b. County	/4	Yrs. City, Town or Lo			July 07	1931 I	reland 10d. Inside City Limits
	with the Ma s or 28a-f s	Director	Md. n/a 10e. Street and Number		Baltimo:	10f. Zip Code		10	g. Citizen of What	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, I're Modical Examiner must be notified at once.	by Funeral Director	625 Stoney Spring 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ≥ [X] No If Yes, Give Year or Dates:		21 21 0 Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	USA American Indian, Vhite, etc. White
21215-0036	within 72 ho lene. 'than "natur I'e Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of worki	ing	6b. Kind of Busine	ess/Industry
Maryland 2	ould be filed Mental Hygi arkad other atic avant, I	To Be C	17. Father's Name (First, Middle, Last) William	Ki	ДД		18. Mother's Name) (First, Middle, M		Hancock
	s 1 and 2 sh f Health and itam 27 is m other traum		19a. Informant's Name/Relationship (Typ. Mrs. Hazel Kidd/ W 20a. Method of Disposition	life 201	625 D. Place of Dispo	ng Address (Street a Stoney S sition (Name of	Opring Dr	. Baltim		21210
Baltimore,	permit. Page: Department o Important: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		illtop 5 R	natory or other place Service Co 2. Name and Address uck Towso 050 York	o. 7-21- s of Facility n Funeral	L Home,]	Towson,	Md.
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Batween Onset and Death
8760, 🛧 📕	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
P.O. Box 68	The law requires that the death certificate be exectled at has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, F	w requires tha been signed should be det	ρ	Part II. Other significant conditions con	tributing to death but not i	resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	X 2	e to the cause of death? Probably 4 □Unknown
		Completed	25. Was case referred to medical					24a. Was an autopsy performs	prior death	autopsy findings available to completion of cause of ?? 'es 2 \(\text{No} \)
Division of Vital	ing Phy After this uneral d	ation: To Be	examiner?	ospital: 1	ER/Outpatien 28b. Time of Injury	t 3 DOA Other	at 2		ce 6 □Other (S	pecify)
Divis	vital or Attend urs after death ral Diractor: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al buildi n g, etc. (Spe				City or Town,	State)	Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medicai	one)	er: On the bast of my ker: On the basis of examinand manner stated.	inowledge, death ination and/or inv	restigation, in my opi	nion, death occurre	ed at the time, date	e and place, and d	lue to the cause(s)
į	T wit		29b. Signature and title of certifier 30. Name and address of person who con	Moderated colors of closely (1)	WV 230) (Time 1		405	290	7 20	OS (OS)
	20		30. Name and address of person who cor CHARLES S. ANGELL, 31. Date filed (Month, Day, Year)		5 FALLS	ROAD, SU	TE 200,	LUTHERVI	LLE, MD	21093
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	Physici	an	Decedent's Name (First, Middle, La.	st)	1 . n			2. Date of Death	Day	Year	3. fine of Death (
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)	LALDO	ARD AN CITY TOWN O	r Location of Death	July ,	4c. Co	ounty of Death	10-17
	Examin	er	SAINT AGNES	HOSPITAC			MORF			NIA	
	Funeral Director		5. Social Security Number 6. S 2/3-36-5636		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV, O	Year) 93	9. Birthpla Count	ace (State or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10	Od. Inside City Limits
	72 hours after death with the Maryland *natural', or items 23a or 28a-f show rdical Exam et must be notified at	Funeral Director	MARYLAND 10e. Street and Number) /A		10f. Zip Code	LTIMOR			n of What Count	1 Yes 2 No
	23s or	a D	25134 LAG	IRETTA A	AVENUE		212	23		USA	,
	items (ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F		14.	Race - America Black, White, e	
21215-0036	72 hours after natural', or ite	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1□Yes 2ÅNo	Specify:		Sp	pecify: 13L	ACK
5-0	72 hours "natural",	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of working d)	19	6b. Kind	of Business/Ind	ustry
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P	be filed within tal Hygiene. ed other than event. It a M	Be C	17. Father's Name (First, Middle, Last)	, 1 4 ~ ~			18. Mother's Name				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>la</u>	D = 0 0	To B	BRACY	L.	ABOA	RD	ELIZA	BETH		BURG	GESS
Maryland	s 1 and 2 should f Health and Mer tem 27 is marke other treumatic		19a. Informant's Name/Re tionship (1	1		and Number or Rural	1 01 0	1	1	- 41
e)	os 1 and 2 of Health item 27	1	DINAH BROWN 20a. Method of Disposition		Ob. Place of Dispo	SACREL position (Name of	Da	ANE, RE	/5/27 20c. Local	tion - City or Tov	40, 2//36 vn. State
Jor	Pages nent of in int: If its		1ÆBurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, cre-	matory or other plac	' 1				E, MD.
Baltimore,	permit. Pages Department of I Importent: If its any njury or o		21. Signature of Funeral Service Licer		2ms	2. Name and Address	ss of Facility BA	POWN	JR.		RAL HOME
			23a. Part1. Enter the disease, or com	plications that caused the							Approximate Interval Between
	Pnysician	ė į	shock, or heart failure. List only Immediate Cause (Final disease or condition	a COMPUCA	na) at	E AAA	REPAR				Onset and Death
	/Medical		resulting in death)	Due to (or as a co		, II A	-21 /11/				1.12.5
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3 %	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions of		ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to the	e cause of death?
Popo	w require been sig		Hyperzension,	ACLOOSIS	HYPER	CHOUS	FUECTAIN	1 Te	s 2 🗆 N	lo 3 ☐ Proba	ibly 4 ŽiUnknown
Rec	as b	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy perform	/	prior to com death?	esy findings available apletion of cause of
AR.		Bec	25. Was case referred to medical examiner?				26. Place of Death				
o to	Physician: this certific ral director,	ို	1 XYes 2 No	Hospital: 1 Minimatient	2 ER/Outpaties		4 Nursing Hom)
	ding After fune	:lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Worl	yat k? Yes 2 □No	8d. Describe ho	w injury o	ccurred	
L A2 Division	or Attenifier deat Sirector: in by the	Certification:	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	e Oga Blace of Injune	At home, farm, sti pecify)			8f. Location (Str. City or Town,	eet and N State)	iumber or Rural	Route Number,
NAME	s Hospitet 24 hours a e Funerel C	Medical C	29a. Certifier 11 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and te and pla	d manner as sta	ited. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licensi	e number	29	d. Date si	igned (Month, D	lay, Year)
	6.) (Ym	MARCUS GA	ANN, IRN	10 ASZ4	38528.320	1 :	suy	20 20	005
	6		30. Name and address of person who		(Item 23a) (Type,		13.4		7,7-	_	
)		MARCUS (SAN) PA 31. Date filed (Month, Day, Year)	32. Registrar's S	HDN A	H. BA	MORE	MD.	402	9.	
	Sta Registr		1111		1.	1 1.					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HELEN PATRICIA MAHT.E /Medical July 23, 2005 3:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 230 Stevenson Lane Rodgers Forge
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) May 25, 19 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Months 1□M 2**X**0F 216-24-8242 Director 77 1928 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Baltimore Maryland Rodgers Forge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 Stevenson Lane by Funeral 21212 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 is marked other than "natural", or itel 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Edward Lacey Marie Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Mahle (husband) 230 Stevenson Land Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 7-26-05 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland Veran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Physician Edema moutus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical as the t attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Failwa 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057740 July 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21286 LASALE Rel 8501 Site Touson 102 MO 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State 2 5 2005 Gostel JUL Registrar

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			Registrar 1. Decedent's Name (First, Middle, I	(act)	Certificate of Death	Reg	No. 2005 24404
	Physic		BENNE	Macil	101	Month /	Day Year 37 Ime of Pearly
	/Medi Exami		4a. Facility Name (If not institution, o	nive street and number)	4b. City, Town, or Lecation	of Death	4c. County of Death
	Exami	iei	(ATOW)	MANON N.H	1. BAITIN	TOVE	NA
	Funeral		5. Social Security Number 6	Sex 7. Age (In yrs.		er 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director	Ι,	218-28-8899	1EM 20F 75	Yrs. Months Days Hours	Min. (Month, Day, Y	Par) 930 SOUTH CANDING
	pu .		Usual Residence of Decedent 10a. State 10b. County	10a Cih	y, Town or Location		
	shor	ঠ	10d. State 10b. County				10d. Inside City Limits 1 ☐ 10s 2 ☐ No
	the N 28a-f	ect	10e, Street and Number	H DA	ALTIMORE	140	
	with a or	Ö	·	11111008	10f. Zip Code	109	Citizen of What Country?
	ns 23	era	1300 S. E.	12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic C	Origin? (Specify Yes or No-	14. Race - American Indian,
10	r then	표	1 Never Married 2 Married	Armed Forces? 1	If Yes, specify Cuban, Mexic		Black, White, etc.
03	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 195	3 1 ☐ Yes 2 ☐ No Specif	y:	Specify: 131 ACK
21215-0036	tiled within 72 hours after death with the Maryland Hygiene ther then "neturel", or Items 23a or 28a-f show ont, the Modical Examinar must be notified at	Completed by Funeral Director	15. Decedent's (Specify only highest of	Education	16a. Decedent's Usual Occupation	nst of working	b. Kind of Business/Industry
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and	t be f ntal l ed ol	Be	17. 1 attel 5 teams (1115), Middle, La	"M. Val.	18. MOI	her's Name (First, Middle, Ma.	(den Sumajne)
Maryland	2 should be and Mental Is marked o	To	19a. Informant's Name/Relationship	(Type Print)	19b. Mailing Address (Street and Num.	bor or Pura Pouto Number C	ity or Town, State, Zip Code 12, 44
Za	and 2 seath ar		MAKY C:	LEC	7020 A 1 ED	Contak On	ity or Town, State, Zip Code (1) 44
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9	8 = 5		1 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spec	Hemovai irom State	emetery, crematory cother place)	104 x0 F	BALTO. IM.
Baltimore,	구두하는		21. Si nature of F neral Service Lic		22. Name and Address of Faci	ility 7829 HU	250 W 37
m	Departing Department of the second of the se		Thomas	A. Afordo	-M. SKARDA I-H.	BALTO	WA 21224
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that caused the death	Do not enter the mode of dying, such a	s cardiac or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Carry	es al lu	La S	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	\ /	3900
	Examiner	_	Sequentially list conditions,	b			
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate muse. Friet underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):		
_	tificate be executed ig physician and as the burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of).		
68760	be e sician buria						
687	ficate p phys is the	edical		0 .			
Вох	leath certi attending i for use a	900	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	DCV		
	death e atte	a					23d. Date of delivery
Ö.	the by th ache	.=	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetat 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	= T 72	hysic		1 ☐ Live birth 2 ☐ Fetat	death 3 Ectopic pregnancy		
s, P	es that the de gned by the a be detached f	by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown contributing to death but not resu	death 3 Ectopic pregnancy	I. 23e. Did tobac	
	equires that sen signed b	by	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	1 ☐ Live birth 2 ☐ Fetat 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy seath 5 Other (specify)	I. 23e. Did tobac	Month Day Year co use contribute to the cause of death?
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Records,	The law requires ate has been sign page 2 should be		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown contributing to death but not resu	death 3 Ectopic pregnancy seath 5 Other (specify)	1 Tes	Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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of Vital Records,	ding Physicien: h. After this certifica funeral director, p	To Be Completed by	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 10 10 10 10 10 10 10	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown contributing to death but not resu Contributing to death but not resu Hospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	althing in the underlying cause given in Part Sectopic pregnancy	24a. Was an autopsy performed 1 Yes 2 Park (Check only one) ursing Home 5 Residence 28d. Describe how	Month Day Year co use contribute to the cause of death? 2 \[\sum \text{No} \] 3 \[\] Trobably 4 \[\] Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 \[\] Yes 2 \[\] No
of Vital Records,	ttending Physicien: death. stor: After this certifica r the funeral director, p	To Be Completed by	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 to 27. Manner eath 1 atural 5 Pending investigati 3 Suicide 6 Could not	1 Live birth 2 Fetal	26. Plac 28b. Time of Injury M 1 Yes 2	24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 3 3 3 3 3 3	Month Day Year co use contribute to the cause of death? 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No a 6 Other (Specify) njury occurred
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of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical Certification; To Be Completed by	in the past 12 months? 1	1	26. Place ER/Outpatient 3 DOA 28b. Time of Injury M 1 Yes 2 Medge, death occurred at the time, date a tion and/or investigation, in my opinion, de	24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No a 6 Other (Specify) njury occurred and Number or Rural Route Number, rate) e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
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ORIGINAL

			1 - For State Registrar	State of M	/larylan		artment of			lental F	lygier Reg. 1	20	05	21 10 =
	*************************************		1. Decedent's Name (First, Middle, La	st)						2. Date of	Death		UJ	3. Time of Death
y s	Physic /Medi		Katherine		Esthe	r	Mu 1	len.		July		2005	Year	11:50 p M
	Examir		4a. Facility Name (If not institution, giv				4b. City, Town		tion of Death			4c. County	ol Death	тт.50 р
ĸ	· Agto	7.	Sommerville Ass						nster			Ca	rrol	1
۲	Funeral		5. Social Security Number 6. S	9ex 7.A □M 2⊠3F		ast birthday)	If Under 1 Ye Months Day		nder 24 Hrs. urs Min.	8. Date of (Month,	Day, Yea	ar)	9. Birthpl Coun	lace (State or Foreign try)
-	Director		215-42-8797 Usual Residence of Decedent		92	Yrs.				June	14,	1923	Ma	ryland
	nand ow		10a. State 10b. County		10c. City	, Town or Lo	cation						10	0d. Inside City Limits
	Mary Fesh	to	MD Balti	more			Pikes		0					1 Yes 2X No
	r 288	Director	10e. Street and Number	more			10f. Zip Cod		<u> </u>		10g. (Citizen of W	hat Coun	try?
	h witl		10 Irving Plac	e			2	1208				U.S.		,-
	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or items 23g or 28a-f show ent. Ite Medical Examination in chilited at	Funeral	11. Marital Status	12. Was Deceden Armed Forces		S. 13. \	Was Decedent of 1 Yes, specify C		c Origin? (Spe	ecify Yes or	No-	14. Race	- America	an Indian,
9	or ite	교	1 ☐ Never Married 2 ☐ Married	1 Yes 2X		1	1 Yes, specify C 1 □ Yes 2√€ N			Hican, etc.)			k, White, e	etc.
8	urei',	d by	3√ Widowed 4 Divorced	Year or Dates:	:		10163 24.1	40 3pe				Specify:	V	White
21215-0036	"net	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	lent's Usual Occ kind of work do	ne durina .	most of worki	ing	16b.	Kind of Bu	siness/Ind	lustry
12	withli ene. then	E G	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use ret	irea)						
0 0	filed Hygin ther		17. Father's Name (First, Middle, Last)			но	usewife	18 M	fother's Name	e (First Midd		Own H		
an	ld be ental ked c	To Be	Frank	Engle				,,,,,,,		ora Fi			2)	
Maryland	shound M	-	19a. Informant's Name/Relationship (19b. Mailin	g Address (Stre	et and Nu					State Zio	Code)
Ž	alth a		Jean Hofmeister	Daught	er		lwood Co						030	,
ore	of He		20a. Method of Disposition			ace of Dispo:	sition (Name of natory or other p			Date		Location - (City or Tov	wn, State
altimore,	Pag ment ant: i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		3	-	ige Ceme	,	July	25,200	05 1	Pikesv	7ille	, MD
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23s or 28a-f show eny injury or other treumatic event, Ite Medical Examine must be indifficed at once.		21. Signature of Funeral Service Licen	see	V		. Name and Add			824 R				
<u> </u>	20 E 9 9	10	Sepher	m ter	Men		ine Fun		Home	Reist	erst			.136
D			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. line.	. Do not ente	er the mode of d	ying, such	h as cardiac o	or respiratory	arrest.			Approximate Interval Between
i i	Physician		Immediate Cause (Final disease or condition	. 130	adde	- 6	ncer							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ									1005
18		<u>.</u>	Sequentially list conditions.	b										
_	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	ence ol):								
	xecul and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a conseque	ence of):								
8760,	cate be executed physician and the burial-transit	dical E	l											
89	ificate g phy as the			d										
ŏ	leath certific attending p I for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	of deliver	v
on O	deatl	icia	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic pregnar Other (specify)				.	Mont		Day Year
о. О	at the by th	Physician/Me	9 ☐ Unknowh	9□ Unknown										
_	law requires that the death certifinas been signed by the attending I should be detached for use as	by F	Part II. Other significant conditions of	entributing to death t	but not resul	lting in the un	derlying cause of	given in Pa	art I.	23e. Dio	tobacco	use contrib	oute to the	a cause of death?
ecords,	w require been si should t	ted								1 []Yes :	2 Z No 3	Proba	bly 4 □Unknown
Ö	e law has b	Completed								24a. We	is an	24b. W	ere autop	sy findings available
<u> </u>	The stee	Con								per 1 ☐ Yes	formed?	_ de	ath?] Yes 2	
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:					lace of Death	(Check only	one)	Bers		Acest 1
ō	Phys	- T	1 Yes 2 No 27. Manner of Death	1 Inpation		R/Outpatient	3 DOA		Nursing Hon			6 C Other		Civil
o	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	28b. Time of Injury	28c. Inj W M 1[ork? ☐ Yes 2		28d. Describe	now inj	ury occurre	3	7
Division	i or Attend after death Director:	fica	3 ☐ Suicide 6 ☐ Could not be		iury - At hon	ne, farm, stre			-	8I. Location	(Street a	ind Number	or Rural	Route Number,
S	after i Dire	Certification:	4 Homicide	building, et	tc. (Specity)	, , , , , , , , , , , , , , , , , , , ,	,,,	-		City or T	own, Sta	te)	0	reals warnes,
	e Hospitel or Ai 24 hours after o Funerel Directels in Installed in by		29a. Certifier Certifying Phy	sician: To the best	ol my know	ledge, death	occurred at the	time, date	and place, a	ind due to th	e cause(s) and man	ner as sta	ted.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	(Check only '2 Medical Exam	iner: On the basis o and manner st	ii examinatio	on and/or inve	estigation, in my	opinion,	death occurre	ed at the time	, date ar	nd place, an	d due to t	he cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	^			29c. Licer	nse numb	er		29d. D	ate signed (Month, D	ay, Year)
	4		1/2046	L M	2		Us.	258	130	>	7	1/22	128	
6	,		30. Name and address of person who o	ompleted cause of d	death (Item 2	23a) (Type, P	rint)		,	torin			2 2	
V	Sta	0	31. Date filed (Month, Day, Year)	32. Regista	The ar's Signatu	tro	St 50	/	403	torin	ste	M	0 4	-115
	Registra		JUL 2 5	2005	MILLE	1.	Someth.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per ME, G245,07/19/05dhb Reg. No. Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ELNORA MASTERS June 10:00 M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johnstopkins Dagview Medical Center Baltimore City Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-23-1920 Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 □ M 2 X F 213-20-9824 Yrs. Director 85 N. CAROLINA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits ns 23a or 28a-f shormust be notified at BALTIMORE Director MD ROSEDALE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 PHILADELPHIA ROAD 21237 U.S.A. or Itams 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other treumatic event, the Medical Exeminer filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT MANAGEMENT ACME STORES 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Pages 1 and 2 should be **JASON** В. **MASTERS** E. NORA (FORBES) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11332 GLEN ARM ROAD GLEN ARM, MD 21057 19a. Informant's Name/Relationship (Type, Print) BROTHER GLEN ARM, MD Health i 21057 DR. JASON M. MASTERS, PHD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō <u>=</u> 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Importent: If eny injury or once. injury or GARDENS OF FAITH CEM 6-8-2005 ^ 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician respiratory 0 11 /Medical Due to (or as a consequence of): **Examiner** herniatio Brainstem compression Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): 4 Examiner burial-transit hemutoma and The law requires that the death certificate be executed COA CERTIFICATION APPROVED Due to (or as a consequence of): Box 68760 trauma by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗙 No or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 2 XXcident 5 Pending Unknown_M Subject fell death 1 Yes 2 No investigation 05/22/2005 after death 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8507 Philadelphia 4 Homicide At home within 24 hours a To the Funerel (Rd., Rosedale, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) N.S. Anderson, Phomo D0062853 June, 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Stanley Anduiss Pho PhO, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 2005 Registrar

				Department of Health and M Certificate of Death		ene . No. 2005	24197
	Physici /Medi		Decedent's Name (First, Middle, Last) Velma Rae Mea	achem	2. Date of Death Month	Day Year 17, 2005	3. Time of Death 8:15 a M
	Examir		4a. Facility Name (If not institution, give street and number) Baltimore Washington Hospital Cente	4b. City, Town, or Location of Death	Burnie	4c. County of Death Anne A	
	Funeral Director		5. Social Security Number 215-28-5766 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birt.	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Young) Dec 18, 1		lace (State or Foreign try) faryland
	72 hours after death with the Maryland natural', or frams 23a or 28a-1 show disal Evantimer must be rodified	Director	10a. State 10b. County 10c. City, Town Md. Anne Arundel 10e. Street and Number	Glen Burnie	100	. Citizen of What Coun	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	72 hours after death with the Maryla "natural", or flams 23a or 28a-1 shov dical Examiner must be notified at	Funeral D	16 Jackson Avenue, NW 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21061 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U.S.A 14. Race - Americ Black, White,	an Indian,
5-0036	72 hours aft natural', or dical Exami	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 ☐ Yes 2 ☐ No Specify: Decedent's Usual Occupation (Give kind of work done during most of work)	16t	Specify: E	Black
d 2121	filed within Hygiene. thar than int, the Me	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)	life. DO NOT use retired) Nurse	e (First, Middle, Mai	Private H	lome
arylan	e d d	To Be	Leroy Nicholson 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b.	Mailing Address (Street and Number or Rura	Mamie	Nicholson	Code)
Baltimore, Maryland 21215-0036	s 1 and 2 of Health of itam 27 is othar tra		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery	r, crematory or other place)	Date 200	Location - City or To	
Baltin	permit. Page Department of Important: If any injury or 9000		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	St. Rest Cemetery 22. Name and Address of Facility Estep Brothers Funer. 1300 Eutaw Place Ba	07/21/05 al Service PA	Hanover,	Md.
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	of enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death Timble Boylow
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Divis	To the Hospital or Attend within 24 hours after death To tha Funeral Director: completely filled in by the 1	al Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farr building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge,		City or Town, Si	ŕ	
	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in it	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	ed at the time, date a	and place, and due to Pate signed (Month, D	the cause(s)
)	107		Rain S. Kaupinem M. D 30. Name and address of person who completed cause of death (Item 23a) (T	D26307 - DYPALDRIVES GL	71	18/05.	7/4
	Sta Registra	-	RANI S. KARI PINENI 325 HOS) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MED GIL	CNDU	NIVESTO	×106/-

Headrem, Velma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 1235PM 2005 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Both (Sca If Under 1 Year If Under 24 Hrs. Arthur 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 1 F -19-876 Director 17 /981 March Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or 28a-f show T is marked other than "natural", or Itams 23a or 28a-f show traumatic sysnt, the Medical Examinar must be notified at 1 FYes 2 No by Funeral Director 3et 10g. Citizen of What Country? 10e Street and Number 20816 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 13 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othin any injury or other traumatic systal place. 18. Mother's Name (First, Middle, Maiden Surname) Be JUDITY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6510 WIT 20816 trither CCA 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 12 Cremation 3 ☐ Removal from State -98 4 ☐ Donation 5 ☐ Other (Specify) Cremetor) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MAM 1332 Midver New Dr. Jessup, 23a. Party. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or real irratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxiation **Physician** /Medical Due (or a consequence of): Examiner bression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner o (or as a consequence of) burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown õ Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached the 9 Unknown certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 5 X Hesidence 6 ☐ Other (Specify) Other: 4 Nursing Home 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Year 5 Pending investigation 1 Natural 28e. Place of Injury - At home, farm, street, factory, office 1 ☐ Yes 2 No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined Location Street and Number or Rural Route Number, City on Jown, Street N1 1#11 Betnesda 3 Suicide mpletely filled in by 4 Homicide 63c3 MacArt. ur Blud, #4, Bethesda nome To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier rouncia 0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ille Pike, G-100, Rock 31. Date filed (Month, Day) ar's Signature 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AVID MONOKER Jul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death RADDAMS TOWN BACTION NORTHWES HESPITAL Conton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NOV. 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 213-32-8267 Director 68 Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23e or 28a-f show Director BALTIMORE 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7920 SCOTTS LEVEL ROAD 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No 3 ☐ Widowed 4 🏋 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) C.P.A. ACCOUNTING other item 27 is marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUIS MONOKER **GERTRUDE** 2 SEIDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a KAREN FERGUSON / DAUGHTER 1201 TRUSLOW ROAD - CHESTERSTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State to = 1 X Burial 2 □ Cremation 3 □ Removal from State 0 Department of Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM. 7/21/2005 HALETHORPE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fyneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSEU DO MONAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by LYMPHOMA STATUS POST CHEMOTHERA 3 Probably 1 🗌 Yes AGUTE ON CHAONICE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 → 10 24a Was an After this certificate has autopsy performed RES DIRATON 1 Yes 2 10 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 12 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 19502 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com-ORIANDO DOUX NAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of N	/laryla				lealth a Death	and M	•	_	000	21 222
(8)	Physic		1. Decedent's Name (First, Middle, L Earl Bernard N	,			-				2. Date of De Month	Reg. No. 2 (Bath 18, 2		5:51A. M
	/Medi Examii		4a. Facility Name (If not institution, g JOHNS HOPKINS BA			CENTER		, Town, or LTIMO	Location o	of Death			nty of Death	
	Funeral Director		216-48-3383	Sex 1 ☑ M 2 ☐ F	Age (In yrs 58	. last birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 11/27/	rth 1946	9. Birth Cou Ma:	pplace (State or Foreign intry) ryland
	Aaryland	o.	Usual Residence of Decedent 10a. State 10b. County MD N/	A		ity, Town or Lo								10d. Inside City Limits 1 ☐¥es 2 ☐ No
	with the Misa or 28a-f	Direct	10e. Street and Number 5081 Orville A	venue				p Code	205	-		10g. Citizen o		
9036	be filed within 72 hours after death with the Maryland nat tygiene. Individual than "naturel", or items 23a or 28a-f show event, I'ra Medical Examination at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 15 Yes 2 If Yes, Give Year or Dates	s?] No		Was Dece If Yes, spe 1 Yes	dent of Hi ecify Cuba		gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	14. R	ace - Amer lack, White	, etc.
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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spec			Place of Dispo cemetery, crer 11aney	natory`or	other place	9)		Date 22/05	20c. Location Balti		own, State Maryland
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4	Physic	ian	1. Decedent's Name (First, Middle, L					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution of SHADY GROVE AD			4b. City, Town, ROCKV	, or Location of Deat	JULY	4c. Coun	005 ty of Death TGOMEI	<u>1535 P ^M</u> RY
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4	the Maryland 28a-f show	ctor	Usual Residence of Decedent 10a. State Orissa, India India Obcounty Bhubane	swar	10c. City, Town or Bhu	Location				11	0d. Inside City Limits 1X Yes 2 □ No
	3a or 26	il Director	10e. Street and Number D41 Gouri Garden	Gouri Nag	ar	10f. Zip Code 7510			10g. Citizen o Indi		try?
920	72 hours after death with the Maryland natural', or items 23a or 28a-1 show alson Exacult wit rust be notilised at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:)	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puerlo Disconsideration of Specify:	pecify Yes or No o Rican, etc.)	o- 14. Ra BI	ace - America ack, White, e	an Indian, etc. n–Indian
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e, Mar	1 and 2 sh Health and am 27 is m ther traum		19a. Informant's Name/Relationship Saurya Prakash Pa 20a. Method of Disposition		sband 31 (Apt. 1,			ecticu	it 06511
Baltimore,	srmit. Pages apartment of iportant: If it iy injury or o		1 ☐ Burial 2 ☒ Cremation 3 (4 ☐ Donation 5 ☐ Other (Special Signature) Funeral Service Lice	ty)	Montgome Cremator	rematory or other pl ry ium, Inc.	20	y 18, 05	Bethese	la, Ma	ryland
m	8858		23a. Part1. Enter the disease, or con shock, owneart failure. List only	aplications that caused			ress of Facility Pumphrey nsin Ave.,			Chase 20814-	3501 Approximate
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	4		30 Name and address of person who	nica-to	AK11 PEN		BALTIMOR	E,MARYL	AND 212	01	
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п	Physici	ian	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death									
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7	Examir	ner	Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore N/A									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth									
	Director		210 22 1737	Yrs. Months Days Hours Min. (Month, Day, Year) Aug. 15, 1928 Maryland									
	and]	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location 10d. Inside City Limits									
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	r 28a	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?									
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Madical Examinar must be rotified at	a D	3665 Keystone Avenue	21211 U.S.A.									
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S				Debenham Court, Baltimore, MD 21236									
ore,	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition 20b. Place of	Date 20c. Location - City or Town, State									
Baltimore	Pages ment of ant: If its ury or o		'4 □ Donation 5 □ Other (Specify) Lakevic	ew Mem'l Gardens 6/10/2005 Sykesville, Maryland									
Balt	permit. Pages Department of Important: If it any injury or one		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Schimunek Funeral Homes									
	40240		Buch a teller 19705 Belair Rd., Baltimore, MD 21236 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate										
			snock, or near failure. List only one cause on each line.	Interval Between Onset and Death									
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of the control of the c	6 weeks									
	Examiner		Aniodom	no toxicity \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \									
	D #	Iner	Sequentially list conditions, if any leading to limit ediate cause. Enter Underlying Cause (Disease or injury	and the state of t									
	be executed iclen and burial-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	/ Wilescoller									
8760,	ate be execu hysiclen and the burial-tra		Due to (or as a consequence of	on): TOXICITY CERTIFICATION REPORTED BY MEDICAL EXAMINER (**COMPANY OF THE OWNER OWNER OF THE OWNER OF THE OWNER OWNER OF THE OWNER O									
687	death certificate be executed e attending physicien and ad for use as the burial-transit	edlcal	d										
ŏ	seath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	23d. Date of delivery									
). B	ne deat the att	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year									
P.0	that the ded by the	Phy	3 LJ OTKHOWH										
ds,	se us	d by	Part II. Other significant conditions contributing to death but not resulting in Hypertension, Renal Insufficiency										
COL	w requir been si should	lete											
Vital Records,	The lay	Completed		24a. Was an 24b. Were autopsy findings available autopsy performed? death?									
a		a l	25. Was case referred to medical	1 ☐ Yes 2 🐼 No									
of V	0 0	To B		tpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specity)									
	te fe			njury Wark?									
Division	Attending in death. ector: After by the fune	icat	3 Suiside 6 Could not be	medication (amiodarone)									
5	i Diffe	Certification:	determined 4 Homicide determined 4 Homicide determined determined 28e. Place of Injury - At home, fame building, etc. (Specify) hospital	City or Town, State Union Memorial									
	Hospital		29a. Certifier 12 Certifying Physician: To the best of my knowledge	Hospital, Balto, MD death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	d'or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	To	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Dey, Year)									
	1		CISULD, MUD	UMP18750 June 7, 2005									
	(13)		30. Name and address of person who completed cause of death (Item 23a) (7	MANAGERIA HOSPITA BARAMAR NA									
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	andua Haspira, Daranitate 1995									
	Registr	ar	JUL 1 1 2005 Block At 1	29c. License number 29d. Date signed (Month, Dey, Year) Type, Print) LMP18730 Type, Print) LMP18740, Balfmore MD									

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			Registrar				Ce	runcau	e of De	atn		Reg. N	2009	
	Physic /Medi		1. Decedent's Name (First, Mid	dle, Last) EU	CE	V.	F	ER	C		2. Dat	e of Death	Zet	3. Time of Deathy
	Exami		4a. Facility Name (If not institut	on, give sti	reet and numb	ber)	< F	4b. City,	Town, or Loca	ation of Dea	th	1 4	c. County of D	eath
	Funeral Director		5. Social Security Number 219-26-5618	6. Sex		. Age (In yrs.	last birthday,	If Under Months		Under 24 Hrs ours Min	8. Date	of Birth oth, Day, Year	9.1	Birthplace (State or Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. Coun	ly		10c. Ci	ity, Town or L	ocation						10d. Inside City Limits
	the Mar 28a-f el	ector	MD. HA	RFO	KD	E	SELA	21R	Codo			10- 0	*** 1AB	1 ☐ Yes 2 ☐ NO
	23e or	al Dir	300 SUN	FL	WE	RI	A.	10f. Zip	210/	1		10g. C	itizen of What ک م	o. A ·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", or items 23e or 28a-f ehow importent: If item 27 ie marked other then "naturel", or items 23e or 28a-f ehow any injury or other traumetic event. The Modical Examination unstablined at ADIGE.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mi 3 □ Widowed 4 □ Divorce	arried	2. Was Deced Armed Force 1 Tes 2 If Yes, Give Year or Date	es?	J.S. 13.	Was Deced if Yes, spec	ent of Hispan ify Cuban, Me	ic Origin? (sexican, Puer pecify:	Specify Ye to Rican, e	s or No- etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc.
9	2 hou	ted	15. Deced	nt's Educa	ation		16a. Dece	dent's Usua	I Occupation			16b. I	Kind of Busine	ss/Industry
21215-0036	within 7 iene. then "n	mple	(Specify only high Elementary/Secondary (0-12		College (1-4	for 5+)	(Give	kind of wor DO NOT us	k done during le retired)	most of wo	orking		(461)	Home
	Hygie Hygie other	ပိ	17. Father's Name (First, Middle	a, Last)			1/1	1-12	18.1	Mother's Na	me (Fjirst,	Middle, Maide	n Sumame)	1 10195
<u>la</u> n	buld be Mental arked o	To Be	4	NK	NOU	UNU				1)1	UK	JO WI	r()	
Maryland	2 should and Men le marke raumetic	_	19a. Informant's Name/Relation				19b. Maili	ng Ad ress	(Street and N	lumber or R	-		or Town, State	e, Zip Code)
	1 and 2 Health tem 27 I		SALY PE	CK			410	MAC	1110	95H	CA	10	PPF,	MD. 2108
ore	ges 1 t of H If iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation	ı 3 ⊟Rer	moval from St	ate 20b.	Place of Disponentery, or e	osition (Nam matory or of	ne of ther place)	MA	Date	20c. L	ocation - City	or Town, State
Baltimore,	tment tent: jury		`4 □Donation 5 □ Other	(Specify)	4 ^-	13	AVVII	Ew (LREM		200	5 B	140.	MD.
Bal	permit. Pag Department Importent: I eny injury c		21. Signature di Filneral Servic	a Lidensee	Aka	Lo	M. 3	Name and	Address of	Facility	287	GHU	D50N	21771
	TO THE		23a. Part1. Enter the disease, shock, or heart failure. Li	or amplica	ations that cau	used the dear	th. Do not en	ter the mode	of dying, suc	ch as cardia	c or respira	atory arrest,	MID	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	n only one	.,		515							Onset and Death
	/Medical		resulting in death)	(a.	Due to (or	as a consec								CAC PERIO
	Examiner	L	Sequentially list conditions,	b.	P	EULE	177							
	be isi	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (or	as a consec		10111						
<u>,</u>	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to (or	as a consec		ELLI	45					
8760,	ate be hysicia the bur	cal		d										
). Box 68	The law requires that the death certificate be executed the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	230		h 2⊡Feta ntattime of d	al death 3	∃Ectopic pre ∃ Other (spe					23d. Date of o	delivery Day Year
P.0	hat the	Phy	9 ☐ Unknowň ` Part II. Other significant condi	tions contr			sulting in the u	ndork inn an		Dard	226	Did tobacco		to the cause of death?
Records,	w requires that been signed t should be det	ted by							use given in		200	1 ☐ Yes 2		Probably 4 Unknown
_		Completed										. Was an autopsy performed? Yes 2 No	prior t death	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
Vital	Physicien: rthis certificaral director,	Be	25. Was case referred to medic examiner?		spital:				Othor	Place of De				
of	<u> </u>	1: To	1 Yes 2 No 27. Manner of Peath		1 ☐ Inp		ER/Outpatier 28b. Time o		4	Nursing H	-	Residence	6 ✓ Other (S _k	pecify) HOSPICE
lon	rth. :: After s funer	atlor	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling tigation	(Month,	Day Year)	Injury	М	3c. Injury at Work? 1 ☐ Yes	2 🗆 No	200. 200		., cooding	
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Place of building	Injury - At h	ome, farm, str fy)	reet, factory,	office		28f. Loca City	ation (Street ar or Town, State	nd Number or e)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in by	edical (29a. Certifier (Check only one) Certify Certify Certify	ing Physic I Examine	cian: To the best or: On the bas and manne	is of examina	owledge, deat ition and/or in	h occurred a vestigation,	it the time, da	te and place, death occu	e, and due urred at the	to the cause(s) and manner d place, and d	as stated. ue to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certif	er				29c.	License num	ber		29d. Da	ite signed (Mo	nth, Day, Year)
	/		IMDum	amo	, m.	O. P.A	7	1	224	188		n≥	5-5-	2005
	1	i ii	30. Name and addr of perso					Print)	10:-	0010	0		7	2005
	(J)		L.M. JUMKI	164, 1	U.D.F.	1/2	20 14	NBRI	06E 1	ELAD,	BALL	More	, MD	21212
	∠Sta Registı		31. Date filed (Month, Day, Yea		3 Reg	istrar's Signa	iure	APRIL S						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/7, perfh, 6846,8/3/05 II

			1 = For State Registrar		partment of Health and F e <i>rtificate of Death</i>	Mental Hygier Reg. 1		21 201
			Decedent's Name (First, Middle, Las			2. Date of Death		3. Time of Death
	Physici /Medi		HANNAH PO	PE.		JULY 21	Year Year	4.50 AM
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	1	c. County of Death	
			NORTHWEST		KANDALLST		BALTI	HORE
	Funeral		5. Social Security Number 6. Se	The other Old	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry)
	Director	ļ	2/5-/2-4/05 Usual Residence of Decedent	86 76 Yrs.		FEB. 12,1	1919 M.	ARYLAND
	/land		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Man Man	ģ	MARKIAND BAI	TIMORE	OWINGS M.	1115		1 ☐ Yes 2. No
	death with the Maryland ms 23a or 28a-f show roust be notified of	lec	10e. Street and Number	,	OWINGS M	10g. (Citizen of What Cou	ntry?
	th wit	a D	5003 HOL	LINGTON DRIVE	21117		45A.	
	r dea	Funeral Director	11. Marital Status		B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ Black, White.	can Indian,
36	s after , or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give	1 ☐ Yes 2 🗷 No Specify:	, , , , , ,	Specify:	otc.
5-0036	hours a tural', c	d be	3 Midowed 4 □ Divorced	Year or Dates:	andreally United Occurration	1 401	10L	ACK
215	in 72 n "nat	Completed	15. Decedent's Edi (Specify only highest grad	de completed) (Giv	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	sing 166.	Kind of Business/In	idustry
212	d with jiene. r thau	mo	Elementary/Secondary (0-12)	College (1-40f 5+)	MESTIC ENGIN		RIVATE	Home
	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Sumame)	7,0776
Maryland	uld by Menta Menta rrked	To E	SYDNEY	SMITH	4 REB	ECCA	DRE	$=\omega$
lan	2 sho and ! Is ma		19a. Informant's Name/Re ationship (T	ype, Print) 19b. Ma	iling Address (Street and Number or Rui	al Route Number, City	or Town, State, Zip	Code)
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-1 show ortant: if item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Evandrational be retified at injury or other traumatic event, the Medical Evandrational be		GWENDOLYN MA		03 HOLLINGTON			5 MD, 21117
ore	Jes 1 of H if itel		20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ 1	20b. Place of Dis cemetery, cr	position (Name of rematory or other place)	Date 20c.	Location - City or To	own, State
Ei m	tment:		' 4 ☐ Donation 5 ☐ Other (Specify	MT, Z	ION CEMETERY 07-	27-05 LA	NSDOWN	VE, MA.
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	1 () ()	22. Name and Address of Cility		Z. FUNEA	RAL HOME
	10200		222 Part Sotor the disease of some	lications that caused the death. Do not e	2140 N. FULT	ON AVE,	SALTO, 1	4021217
В			shock, or heart failure. List only o	ne cause on each line.	riter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. THEUMS	ALF			& DAYS.
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	E O E	-	IF FEMALE:					
Вох	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ery Day Year
o.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by Physician/A	1 ☐ Yes 2 🖪 No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)			
Ω.	that the ded by detail	/ Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Records,	uires 1 sign 1d be					1 🗆 Yes	2□No 3□Prob	pably 4 Munknown
00	w requir been si should I	Completed				24a. Was an	24b Were auto	psy findings available
Re	sician: The law certificate has b irector, page 2 s	mc				autopsy performed?	prior to cor death?	mpletion of cause of
Vital		o o	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 💢 N h <i>Check onlone</i>	lo 1 Yes	2 KU No
>	> 0 0	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	Other	ome 5 Residence	6 FlOther (Specif	(v)
υot	- E	T iu	27. Manner of Death	28a. Dite of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how inj		,,
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Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta		I Route Number,
	urs af	Ce						<u></u>
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause(red at the time, date ar	s) and manner as st nd place, and due to	tated. o the cause(s)
	o the o the o the omple	Mec	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d. D	ate signed (Month,	Dav. Yearl
			> googinder PM	efter m.o	D41410	Jul	FF and	2015.
	10		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type		MCUTA	1 ' /	
1	4		MONTH WEST HUSh	^	ANDAUSTELLY M		` '	
	Sta	te	31 Date filed (Month, Day, Year)		book		4	
	Registr	ar	3012 2 2	TOUS MANUEL ST.	GOOGL!			

Physici	ian		ne (First, Middle, Li	,			rtificate				2. Date of De Month	Reg. No. 2	Year	3. Time of Death
/Medi Examir	cal	<u>-</u> -	.na Robl (If not institution, gi		nber)		4b. City, To	own or	Location	of Death	June	24,	2005	1:15 P
LXaiiiii	iei		RUN ASS			ING			VILI				BALTI	MORE
Funeral Director		5. Social Security I 215-01- Usual Residence of	2789	Sex 1□M 2⊅F	7. Age (In yrs.	98 Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4/28/1	ly, Year)	9. Birthp Cour Mary	,
or 28a-f show	tor	10a. State	10b. County BALTI	MORE	10c. Cit	ty, Town or Lo	ocation MIDDLI	E RI	VER				1	0d. Inside City Limit
3a or 28a	I Director	10e. Street and Nu 1205 AP	umber PPARITION	LANE		2,000	10f, Zip C		220			10g. Citizen d	of What Cour	ntry?
ial Hygiene. d other than "natural", or items 23a or 28a-f show evant, I're Medical Exeminer must be nutified at	by Funeral		ried 2 Married	12. Was Dece Armed For 1 Yes If Yes, Giv. Year or Da	2 X No e		Was Decede If Yes, specif			gin? (Spe I, Puerto	ecify Yes or No Rican, etc.)	- 14. R B	tace - Americ tlack, White, cify: WH	
and Mental Hygiene. Is marked other than "natural", aumatic evant, I're Medical Exe	Completed	(Spe Elementary/Sec 8	15. Decedent's E cify only highest gr ondary (0-12)	ducation rade completed) College (1	-4or 5+)	(Give	dent's Usual kind of work DO NOT use HOMEN	done di retired)	u <i>ring mos</i> i	t of worki	ng		Business/Ind	
	To Be	17. Father's Name HENRY	(First, Middle, Last	WAGN	ER				18. Mothe		(First, Middle,	Maiden Sum	ame)	
Ith and Men 27 Is marke traumatic			lame/Relationship				APPAR				Route Number			Code) 21220
Department of Health ar Important: If item 27 Is any injury or other trau once.			sposition Cremation 3 [5 Other (Speci		C	Place of Dispo	natory or oth	er place	e) (-2005	20c. Location		wn, State
Departm Importa any inju once.			uneral Service Lice		2		2. Name and				TH/ROSE	DALE FU		HOME 21237
nysician Medical		shock, or head shock, or head shock, or head shock, or head shock, or condition resulting in death)	(Final on	a. Fu	aused the death	h. Do not ent. herosc								Approximate Interval Between Onset and Death
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			1 - For State Registrar		ryland / Depa	artment of Health and rtificate of Death	Mental Hygi	_	24206
	Physici /Medi Examir	al	Decedent's Name (First, Middle, Last, Frank John Ramos Aa. Facility Name (If not institution, give 3118 Cornwall Road	ska street and number)	7.77	4b. City, Town, or Location of Dea Dunda1k	2. Date of Death Month July 19	, 2005 Year 2005 4c. County of Death Baltimore	
***	Funeral Director		210 10 3000	x 7. Age	(In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min		Year) 9. Birth Cou 23 Ma	place (State or Foreign ntry) aryland
	he Maryland 28a-f show ciffied at	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	ore	10c. City, Town or Lo Dundall	ζ			10d. Inside City Limits 1 ☐ Yes 2√1\No
	th with t	Funeral Director	3118 Cornwall Road	d		10f. Zip Code 21222	10	g. Citizen of What Cou U.S.A.	ntry?
036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28a-f show thit, the Medical Exament must be tradified at	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	etc.
1215-0	within 72 ho ene. than *natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le <i>completed)</i> College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) oping Receiving	orking 1	6b. Kind of Business/Ir	adustry
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Frank John Ramoska			18. Mother's Na Elizat	me (First, Middle, Moeth Silan	ski	
	and 2 shualth and 27 is m		19a. Informant's Name/Relationship (Ty David Rasel Sr.	rpe, Print)		ng Address (Street and Number or R Cornwall Road Du			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examener must be notified at ance.		20a. Method of Disposition 1 ™ Burial 2 ☐ Cremation 3 ☐ P 1 ☐ Donation 5 ☐ Other (Specify) 21. Signary of Funeral Service License		Sacred He	sition (Name of natory or other place) eart of Jesus 7/2 . Name and Address of Facility Cl	22/05	Oc. Location - City or To Baltimore,	Maryland
Ba	Depa Impo Impo		> Clegabille	Evas	6	224 Eastern Avenu	ue Baltimo	re, Maryla	
68760,	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires the law representation and representation and representation as the purial-transit or use as the burial-transit.	dical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	9.	otie Candiou			Approximate Interval Between Onset and Death
P.O. Box (that the death certifical hed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	эгу Day Year
rds, P.	w requires that to be the signed by should be detailed	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the ur	iderlying cause given in Part I.		acco use contribute to the	ne cause of death?
al Records,	iician: The law re certificate has be rector, page 2 shu	Completed					24a. Was an autopsy perform 1 Tes 2	prior to co	psy findings available mpletion of cause of
f Vital	Physician this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 \(\triangle \text{No} \)	lospital:	t 2 ER/Outpatien	Other	ath <i>(Check only one)</i> Home 5 X Residen	ce 6 Other (Specif	y)
Division of	Attending Physician: If death. ector: After this certifies by the funeral director, is		27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. escribe how	injury occurred	
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h, completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.			City or Town,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in its completely	edical	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occurred.	e, and due to the cau urred at the time, dat	se(s) and manner as si e and place, and due to	tated. the cause(s)
	To the vithir comp	Ň	29b. Signature and title of Cartifier	N N -	L,	29c. License number		d. Date signed (Month,	
	h		37. Fiame and address of person who co	mpleted cause of de	ath (Item 23a) (Type, I	918661		ruly zo,	2005
	Sta	te	PHILIP MILITELLO, 1 31. Date filed (Month, Day, Year)	MD 6 Trim 82. Registrar	's Signature	CT. Lutherville	Maryla	nd 210	43
	Registr		JUL 2 5 2005	Silver and	Dr. Does				

			1 _ State	nd / Department of Health and N	Mental Hygid	ene
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg	NO 005 24207
	Physici	an	EDNA BERNETTA	STRACCUER	Month	Day Year 3. Time of Reathy
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	ABSSIVER 4b. City, Town, or Location of Death	suy !	4c. County of Death
	Exami	iei	FUTURE CANTE CANTE	BAITIMODE		NA Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign
	Director		212-24-8095 10M 2XF 91	Yrs. Months Days Hours Min.	MAY 12	ear) Country MD.
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. C	T		
	sho	5	100. County	ity, Town or Location		10d. Inside City Limits
	the M	Director	10e. Street and Number	HUINOKE		1 ☐ Yes 2 ☐ No
	with a or	급	O L 7 I	10f. Zip Code	10g	. Citizen of What Country?
	eath	eral	11. Marital Status 12. Was Decedent Ever in U	QD . 21236	acifu Van an Na	U.S.H.
	iter d	F	Amed Forces? 1 New Married 2 Married 1 Yes 2 No	J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
99	al', o	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: //)///
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Eratic or Linual be invitiged at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	16	b. Kind of Business/Industry
2	ithin Ban "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	1/
7	ed with ygiene. ner thau	S	12	HOME MAKEA	6	OWN HOME
E L	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	1
Maryland	should nd Men marke imatic	٦ ک	ALBERT P. REDDI			4NDERSON
Mai	12 sh h and 7 Is m fraum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zip Code)
	1 and 2 Health em 27	ं	20a. Method of Disposition 20b.	Place of Disposition (Name of	Pate 200	9670. MD. 21236
ltimore,	Pages nent of h int: If ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cometery, crematory or other place)	V 18	c. Location - Gify or Town, State
≣			' 4 Donation 5 Other (Specify)	OCHERET OF JESUS	2005	BALTO MD.
Ba	permit. Departrimonts Imports any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	829 140	DO SON 57.
			23a. Part 1. Enter the disease promplications that caused the deal	Do not enter the mode of duing such as cardian	SAUC; H	1D 21224 Approximate
		V.	23a. Part1. Enter the disease, by complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final	To deliver the mode of dying, such as cardiac.	+ D	Interval Between Onset and Death
	Prrysician /Medical	1	disease or condition resulting in death)	vscherve Hear	1 1115	pase
	Examiner		Due to Du	LOS clerosis		
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec			
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ	an an rial-tr		resulting in death) Last Due to (or as a conseq	uence of):		
8760	cate be executed physician and the burial-transit	dicai	d			
9	ng ph as tl		IF FEMALE:			
Вох	eath certifi attending for use as	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta			23d. Date of delivery
0.	e dea the at ned fo	Physician/Me	1 ☐ Yes 2 MNo 4 ☐ Pregnant at time of d 9 ☐ Unknown 9 ☐ Unknown			Month Day Year
<u>т</u>	res that the de igned by the a be detached f	Phy	3 Olikilowii			
ecords,	law requires that the death certificate been signed by the attending to should be detached for use as	by	Part II. Other significant conditions contributing to death but not res	wring in the underlying cause given in Part I.		co use contribute to the cause of death?
0	w require been si should b	etec			1 Yes	2 Probably 4 Unknown
Hec	has h	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a E	That are pag				performed 1 ☐ Yes 2 💆	
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
ō	Phys	To.	1 Yes 2 No 1 Inpatient 2 2. 27. Manner of Death 28a. Date of Injury			6 Other (Specify)
on	fing Afte fune	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how i	njury occurred
Division	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At he		28f Location (Street	t and Number or Rural Route Number.
\leq	after after Dira	Certification:	4 Homicide determined building, etc. (Specif	y)	City or Town, S	
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune		29a. Certifier Certifying Physician: To the best of my kno	wledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as stated.
	n 24 he Fu he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or investigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
	To t To t	ž	29b. Signature and title of conflient	29c. License number	29d.	Date signed (Month, Day, Year)
	1		1 / 6 20 1/2	W11150	1/	115/2005
6	, ~		30. Name and address of person who completed cause of death (Item	1 23a) (Type, Print)	5 DA: -	. MO 2122 W
V_)		MELITO M. TOURES, M. 9	tion and/or investigation, in my opinion, death occurred to a construction and/or investigation, in my opinion, death occurred to a construction of the construction o	BALTO	D, WIY SHATT
	Sta	-	31. Date filed (Month, Day, Year) 32. Redistrar's Signa	ture Knack)		
	Registra	al	JUL 2 5 2005 Mayer	No. Value		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 22, 2005 Sally т. Sweetman July 4:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 225 Frock Drive Apt 221 Westminster Carroll 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F Yrs. **Director** 214-38-6361 65 1939 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Evanti part oust be notified at 1 ☐ Yes 2X No Director Carroll Westminster 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 225 Frock Drive USA Apt 221 21157 death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Parker Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Tove11 Haze1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott G. Parker Son 3201 Walnut Avenue Owings Mills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7/26/05 Druid Ridge Cem. Pikesville, Maryland 21. Sign rura I meral S ce Licease 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Maryland 21136 me 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im diate Cause (Final dease or condition resulting in death) Pnysician Small Cell CA Comos /Medical **Examiner** 3mes Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit Chronocohern Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident Injury 5 Pending death. 1 □ Yes 2 □ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1) Certifying Physician: To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and due to the cause (s) and manner stated. Medical (Check only for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who

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th (Item 23a) (Type, Print)

2 horas beine

			1 - For State Registrar	State	of Maryland	-	artment o			and M		iene) 5	21.200
			Decedent's Name (First, Middle	. Last)							2. Date of Deat	h	L-U	3. Time of Death
	Physici	an	Matilda	М.	Strevig						July 24	Day 2005	Year	7:10 p M
	/Medic		4a. Facility Name (If not institution,				4b. City, To	own. or	Location of	f Death	July 24	4c. County	of Death	
	Examin	er	Chapel Hill				1		11sto					
			5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1		If Under 2		8. Date of Birth		11tim 9. Birth	plece (State or Foreign
	Funeral Director		214-03-3232	1 □ M 2 🖾 F	86	Yrs.	Months D	Days	Hours	Min.	(Month, Day, April 5	Yeer)	Cou	ntry) Vland
			Usual Residence of Decedent		00						MPLIL J	, 1/1/	Hai	yıanı
	ylanc # #		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Mar	ţ	MD Ba	ltimore		W	oodlaw	m						1 ☐ Yes 2 No
	r 286	Director	10e. Street and Number		1		10f. Zip Ci				1	0g. Citizen of V	Vhat Cou	ntry?
	h witi	<u></u>	7507 Flint	y Plain D	rive			21	244			U.S	S.A.	
	deat	ner	11. Marital Status		edent Ever in U.S.	13.	Was Deceder	*****		gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac		ican Indian,
9	or the	by Funeral	1 ☐ Never Married 2 ☐ Marri		21 No	1	1 □ Yes 21€		Specify:	, , , ,	riodii, oto.,	Specify		
ဋ္ဌ	ours	g	3X Widowed 4 □ Divorced	Year or I	Dates:		103 22	3110				Specii)	. W	hite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hyglene. wher then "neturel", or Hems 23a or 28e-f show with the Medical Examinat must be notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed;		(Give	dent's Usuat (kind of work	done d	lurina most	t of workii	ng	16b. Kind of Bu	ısiness/Ir	ndustry
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7	ygier r. f.	Ö	12				Homem	iake		1. 11.	(F 1514): 1		Home	2
밑	be fil d oth	Be	17. Father's Name (First, Middle, I	_ast)					18. Motne	rs Name	(First, Middle, M	naiden Suman	ю)	
Ş	should be i and Mental I s marked o rumatic eve	၉	Emory Marshal								Kreiger			
<u>la</u>	2 sh and is m		19a. Informant's Name/Relationsh	nip (Type, Print)							l Route Number	5000		p Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumsitic event, the Medical Exertires must be notified at		Phyllis Malone	Daugh			Cindy Sition (Name		e, We		nster,			Comp. Canada
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other ance.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from		netery, crei	natory or othe	er place	9)		ale	20c. Location -	City of 1	own, state
Ē	Pag men tent:	١.	* 4 □ Donation 5 □ Other (Sp		Lake		Mem.			7/27/		Sykesvi		
E E	epart epart pod ny in		21. Signature of Funerall Service I	icens e			2. Name and			•				own Road
ш_	20199	7 1	John (X)	year			line F						<i>m</i> , M	ID 21136
			23a. Part1. Enter the disease, or shock or heart failure. List	only one cause on	each line		er the mode of					est,		Approximate Interval Between
Z	Pnysician	8 V	Immediate Cause (Final disease or condition		1/2 heim	1813		D	ema	n f.	~			Onset and Death
	/Medical		resulting in death)	Due to	(or as a conseque	nce of):							13	
	Examiner		Sequentially list conditions.	b										
-	ס ∺	le l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage of Injury	Due to	(or as a conseque	nce of):								
	acute ind trans	am	that initiated events resulting in death) Last	c										
Ö,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ical Examiner	rosaling in south, Last	Due to	(or as a conseque	nce on:								
8760,	ate b hysic the b	lca		d										
9	that the death certific: ed by the attending pl detached for use as t	Med	IF FEMALE:	22. 11										
Вох	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregnance birth 2 ☐ Fetal d	eath 3[Ectopic preg					23d. Dat Mo	te of detiv nth	ery Day Year
~	e de the a	sic	1 □ Yes 2 □ No 9 □ Unknown	4∐Preg 9□Unkr	nant at time of dea nown	th 5L	Other (spec	ify)						
P. 0.	d by etach	F.		na contribution to	donath brus mas manufit	inn in the	a dachtian ann		n in Cort I		23a Did tol	acco use cont	ributa to I	the cause of death?
	w requires that s been signed b should be deta	ρ	Part II. Other significent condition	ns contributing to t	Jeath Dut not result	ing in the u	ndenying cau	ise give	mirani.			_		bably 4 Dunknown
50	inper seen s	Completed								_		3 2 5 70		
Ö	e law i has b	ple									24a. Was a autops	y	orior to co	opsy findings available ompletion of cause of
<u>~</u>	Physiclen: The this certificate har all director, page	Son									perform 1 ☐ Yes 2		death? I 🗌 Yes	2 □ No
ita	Physiclen: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?						26. Ptace	of Death	(Check only on	ө)		
<u>~</u>	hysic his ce I dire	은	1 ☐ Yes 2 ☐ No			R/Outpatier	nt 3□ DOA	Othe	4 2 Nu		ne 5□Reside			fy)
0	ding Phys J. After this funeral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	8b. Time o Injury	f 28c	. Injury Work	at		28d. Describe ho	w injury occurr	ed	
Sio	Attending ir death. ector: After by the fune	atl	2 Accident investig	ation			М	101	res 2 □ l					
Division of Vital Records,	l or Attencafter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	289. Plac	e of Injury - At hom ling, etc. <i>(Specify)</i>	ie, farm, sti	eet, factory, o	office		1	28f. Location (St. City or Town		er or Run	al Route Number,
Ω	itel c													
	Hospitel	ical	(Check only 2 Medicel !	examiner: On the l	e best of my knowl pasis of examinatio	edge, deat in and/or in	h occurred at vestigation, in	the tim	ie, date an pinion, deal	d place, a th occurre	and due to the ca ed at the time, da	iuse(s) and ma ate and place, :	nner as s and due t	stated. to the cause(s)
	the state	Medical	one) 29b. Signature and title of certifier	and mai	nner stated.		290 1	licenee	number		2	9d. Date signe	d (Month	Dav. Year)
	5 th 5 no			1. Mm	MI	7		1	00	2				
à	di		, , , , , ,		7-17	–						1/6	1	ل د
1)		30. Name and address of person	inn	114	23a) (Type,	Print)	(and	-	D. K.	2:1/20	10-	- MS 21136
_	/		31. Date filed (Month, Day, Year)	30	Pegistrar's Signatur	re					•			
	Sta Registr	-	1111 9 5	2005	egistrar's Signatu	· A	acti							
				LUUJ A	CHELINA .									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 0 0 5 3 Fine of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 24, 2005 Year Smith Mary 5:45 А. м /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. September 21, 1916 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Director 88 215-05-4750 Mary Tand Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show. The Wedical Examiner must be notified at 10d. Inside City Limits Directo Mary land Baltimore Parkville 1 ☐ Yes 2(X)No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 Walther Boulevard 21234 Be Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Waitress Restaurant other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Hartman 2 Josephine Neff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Zittle/Grandson 8118 Rose Haven Road Baltimore Maryland 21237 of Health a item 27 Is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State ō = 6 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Moreland Memorial Park `4 ☐ Donation 5 ☐ Other (Specify) 7/27/05 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final Physician renal disease or condition resulting in death) cell carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Josease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 Ho 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Vital 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Trursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5864 Maria 25. 2005 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Tovah nonias Dak 31. Date filed (Month, Day, Year) Registrar's Signature State 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 Year **Physician** 21 Gertrude Saur July 6:25 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3548 Chesterfield Avenue Baltimore City N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 2,1918 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 86 Maryland Director 214-01-0856 Usuel Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impurtant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A 1 ☑ Yes 2 ☐ No Maryland Baltimore City Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 U.S.A. 3548 Chesterfield Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced ear or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stagmer Margaret Shipley Elmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3548 Chesterfield Avenue Mr. William C. Saur - Husband Baltimore, MD 21213 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Hilltop Service Corp 7/25/05 Towson, MD '4 □ Donation 5 □ Other (Specify)

21. Signature of Juneral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 aur Kerlau Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pack line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER OF THE **Physician** disease or condition resulting in death) /Medical 20 years Examiner Sequentially list conditions, if any, leading to immediate cause. Entire United his Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Seldence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Hospitei or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident **Director**: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeref L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and D15462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200E. 33rd St H. KARACUSCHANSKY MIGUEL 32. Regitrar's Signature 31. Date filed (Month, Day, Year) State 5 Registrar

			For Stete Registrar	State of I	Maryland / Dep <i>Ce</i>	ertificate of			ene 2005	24212
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death)	3. Time of Death
	Physici		Dorothy G	. Smith				July 21	. 2005	1:00 A.M
	/Medid Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death	0017 21	4c. County of Death	
			7115 Rockridge	Road		Baltin	more		Baltimore	County
	Funeral		5. Social Security Number		Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		216-28-4335	1□ M 2□ X F	100 Yrs.	lilenano, Bayo	110010	July 1		linois
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Aaryli I sho	ō	Maryland Baltin	nore		timore				1 □Yes 2 No
	28a-	ect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	into/?
	72 hours after death with the Maryland natural', or items 23e or 28a-f show dissi Evarif vermusi be codified at	Funeral Director	7115 Rockrid	ge Road		2120	7		U.S.A.	
	ns 2	era	11. Marital Status	12. Was Decede	ent Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
(0	riter or item	Fur	1 Never Married 2 Marrie	Armed Force	₩ No	If Yes, specify Cuba		Rican, etc.)	Black, White	
03	al', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
21215-0036	72 hc natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a, Dec	edent's Usual Occup	ation during most of work	cina 1	6b. Kind of Business/li	ndustry
2	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retired	d) -			
	filed w Hygier kthar tt	S	12	2	Mu	sic Teache			Self Employ	yed
and	be fi	Be	17. Father's Name (First, Middle, L Michael	*	Gillen		Margar	e (First, Middle, M	Huetter	
Maryland	should be filed within 72 hours after death w nd Mental Hygiene. I marked other than "natural", or items 23e umetic event, if a Medical Evar if at must	10	19a, Informant's Name/Relationsh		,	ling Address (Street			City or Town, State, Zi	in Code)
Ma	o se se		Miss Jean G. Sm			Rockridge			, MD 21207	p C008)
ē,	Health tem 27 ther tre		20a. Method of Disposition		20b. Place of Disp	position (Name of	1		Oc. Location - City or T	own, State
OF.	Pages nent of nrt: If it ry or o		1 Burial 2 Cremation 4 Donation 5 Other (Sp		210	ematory or other place In Cemeter		5-05	Baltimore,	MD
Baltimore,	- 트립크		21. Signature of Funeral Service L	* '		22. Name and Addre			Maryland	21214
ã	Departiment of the control of the co		+ fant I.	Sonteal	K	Leonard J			5 HArford	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cau	ed be death. Do not er					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pana	reatic Co	ancer 1	ith o	hetruc	tive	Onset and Death
	/Medical		resulting in death)	a Due to (or	reatic Coas as a consequence of):			jauno	lice	5000
8	Examiner		Sequentially list conditions,	b. ————				5		
	י מ	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c						
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	physic stee	dlcal		d						
9 X	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy				22d Date of dollar	200
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birtl	h 2 🗆 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	′		23d. Date of delive Month	Day Year
0	that the death led by the atter detached for u	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow						
<u>α</u>	res that igned b	y P	Part II. Other significant condition	s contributing to deat	th but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w requires been sig should b	ed b	stroke					1 ☐ Yes	3 ☐ Pro	bably 4 □Unknown
Records,	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	plet	scizure o	lisord	er			24a. Was an		opsy findings available
Ä	The lav	Completed by	cerebrovo			ie.		autopsy perform		ompletion of cause of 2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		-
of V	Physician: this certific ral director,	인	1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing Ho	ome 5× esider	nce 6 Other (Speci	fy)
n		on:	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of (Month,	Injury 28b. Time Day Year) Injury	Wor	k?	28d. Describe how	v injury occurred	
sio	Attending r death. ector: After oy the fune	catl	2 Accident investigation inves	nt he			Yes 2 □No	201 1		10
Division	or Al after of Direction by	Certification:	4 ☐ Homicide determin	289. Place of	Injury - At home, farm, s , etc. <i>(Specify)</i>	treet, factory, office		City or Town,	et and Number or Rur State)	ai Houte Number,
ч	Hospital	2	29a, Certifier Certifying	Physician: To the b	est of my knowledge, dea	th occurred at the tin	ne, date and place	and due to the car	Ise(s) and manner as	stated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E	xeminer: On the basi and manner	is of examination and/or i	nvestigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	-1 1	7	29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
	OX		Macun	and	₹\m	D 4	-6504	9	uly 21,	2005
1	5-1		30. Name and address of person w	no completed caus	of death (Item 23a) (Type	o, Print)	Same	aiteras H	nspital.	
-			Nancy Jabe	taven	THE ME	Bachd	10re	21239	uly 21, is pital	
		ate	31. Date filed (Month, Day, Year)		istrar's Signature	1 .				
	Regist	rai	.1111. 2	5 2005	an K	Braues				

ORIGINAL

			3a,27,28a-t per me	partment of Health and C846 8-8-95 tas enflicate of Deaths	Reg	. No 2005	24213	
Physic /Medi		Decedent's Name (First, Middle, Last	William R. Sta	ten	July 16,	2005 Year	3. Time of Death 7:59 P M	
Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death		
A None	M	University Hospit	al	Baltimore If Under 1 Year If Under 24 Hr	S Q Data of Birth	N/A		
Funeral Director		5. Social Security Number 6. Se 212-46-9648 Usual Residence of Decedent	7. Age (In yrs. last birthda Yrs. 58 Yrs.	Months Days Hours Min			lace (State or Foreign try) laryland	
e Maryland 3a-f ehow tiffed at	Director	10a. State 10b. County Md. N	10c. City, Town or	Location Baltimore		1	0d. Inside City Limits 1 X Yes 2 □ No	
th with th	al Dire	10e. Street and Number 3409 Wabash Avenue		10f. Zip Code 21215	100	g. Citizen of What Cour U.S.A	-	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Iteme 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	8. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 XNo Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Americ Black, White, Specify:		
C 608	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Giv	edent's Usual Occupation re kind of work done during most of w DO NOT use retired) Skill Worker	orking 16	Sb. Kind of Business/Ind		
should be filed within and Mental Hygiene. marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) William R.	Staten Sr.	18. Mother's Na	ame (First, Middle, Ma	ha Staten		
ith ar 27 ts r trau		19a. Informant's Name/Relationship (7) Odessa Whittington Sist		iling Address <i>(Str</i> eet a <i>nd Number or F</i> 3409 Wabash Avenue Bal			Code)	
		20a. Method of Disposition 1 □ MBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	removal from State	rematory or other place)	Date 20	oc. Location - City or To		
permit. Page Depertment of Importent: If eny injury or once.		21. Signature of Funeral Service Licens	11.00.23	owndge Memonal Park 22. Name and Address of Facility Estep Brothers Fur 1300 Eutaw Place	neral Service PA	4		
Medical Sician and Sician and Purial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
at the death certificate by the ettending physi	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy		23d. Date of delive Month	ry Day Year	
quires that n signed b uld be deta	by	Part II. Other significant conditions co	ntnbuting to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th		
an: The law requires that the ilicate has been signed by th or, page 2 should be detache	e Completed	25. Was case referred to medical				prior to con death?	osy findings available npletion of cause of 2 No	
Physicien: this certific ral director,	o B	examiner?	lospital: 1XXnpatient 2 ☐ ER/Outpati	Other	Bath (Check only one)	ce 6 Other (Specify	al.	
After After fune	tion: T	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 4-21-2004 28b. Time Injury 4:04	of 28c. Injury at	28d. Describe how	injury occurred	/	
To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Attecompletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	P	28f. Location (Stre City or Town,	et and Number or Rura. State) 1031 W. e, Maryland	Stricker S	
e Hospital	Medical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sician: To the best of my knowledge, dei ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cau	se(s) and manner as st	ated.	
ithir imp	Me	29b. Signature and title of certifier	QAR'	29c. License number O.C.M.E.		Date signed (Month, left)		
2 1 2 5		commune						
District S			ompleted cause of death (Item 23a) (Typi	1 Penn Street, Ba	ltimore, M	Maryland 2	1201	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MOSGMIC 00 A M ari July 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BaltinoRe Imal DUNHAVEN If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F Months Hours Min 214-26-7674 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Items 23a or 28e-f ehow treumatic event, the Medical Examiner and be notified at 1 ☐ Yes 2 No Director Daltmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Koaa death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene Importent; if Item 27 is marked other then "neturel", or Item inportents of the marked other then matter event, the Marical Examines once. 1 Newer Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Milton E. Ceunney 1ar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) SIMPSON LWay IMMERE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lawy Cemekry 05 ^¹ 4 □ Donation 5 □ Other (Specify) Ba 22. Name and Address of Facility Bradgy-Ashton Fund 21. Signature of Funeral Service Li 1 Home P.A. Funcea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dementia ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner infarcts cerebral multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transi hyper tension
Due to (or as a consequence of): ears and that initiated events resulting in death) Last Box 68760. attending physician Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached the 9□ Unknown 9 Unknown ð Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Division of Vital Records, 2 þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parkinsonis Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 2 No certificate 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062032 19, 2005 30. Name and address of herson who completed cause of death (Item 23a) (Type Print)

JENNIFER HAYASHI, MD SSOSHOPKINS BAYVIEW CIRCLE, BALTIMORE, MD 21234 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

ORIGINAL

amend item#20a, per Fri, 6845, 7/25/05 IT State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No.2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18:48 M COTT 18TH JULY 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BAYVIEW BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** XXM 2□F Director 216-66-3803 50 SEPT. 2. 1954 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral, or items 23s or 28s-f show Exercises must be notified at 1 Yes 2 □ No MD BLATIMORE TURNER STATION Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 CHESTNUT STREET 21222 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1☐ Yes 2√XNo Specify: Specify: BLACK δ 3 ☐ Widowed 4 █ Divorced Completed the Mudical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) BROADWAY SERVICES 12 LABORER other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importsnit: If Item 27 is marked other any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES V. SCOTT 2 EFFIE WALKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 130 DORSEY DR., EDGEWATER, MD 21037 JAMES V. SCOTT/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition rial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 7/23/05 BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee ames Of. In 1701 LAURENS ST., BALTIMORE, MD 21217 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IDIOPATHIC DILATED CARDIOMYUPATHY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Yea 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. To the F within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 18TH RES 001 Istrow MD PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERY AVENUE, BALTIMORE, MD 21224 LYLE W. OSTROW AD PLD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				For State Registrar	State of M	-	epartment o Certificate o	f Health and of Death		giene	0 ==	
		Dhuaiai		1. Decedent's Name (First, Middle,	Last)			-	2. Date of Dea	ath Z U	U D Yeer	3. Titue of Death
		Physici /Medic	al	Mary	В.	Smuti			July	22, 2	005	12:40A ^M
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		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any righty or other traumatic event, Ite Madical Exaction must be notified at ance.	to	Maryland Baltin	nore	10c. City, Town o					1	0d. Inside City Limits 1 ☐ Yes 2 100
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		r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- Americ	ean Indian,
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35	ar)	2 sho and P is ma	ľ	19a. Informant's Name/Relationshi	э (Турө, Print)	19b. M	lailing Address (St	reet and Number or R			State, Zip	Code)
2005	≥,	and sealth m 27		<u>Anita M. Christo</u>	opher Daugh		Kaufman		kton, Ma			
6	Baltimore,	ges 1 t of H Hital or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3	B □Removal from State	20b. Place of Di cemetery	isposition (Name of crematory or other Hear C Of	place)	Date	20c. Location -	City or To	own, State
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•				23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause nly one cause on each	ed the death. Do not line.	enter the mode of	dying, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
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		0		30. Name and address of person w	ho completed cause of	death (Item 23a) (Ty	rpe, Print)			. /		
		12		DR. TARIQ MAHM		DULANEY VA	ALLEY RD.	TIMONIUM	1, MD 210	93		
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Juanita Thornton

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Funera Directo		5. Social Security Number 6 212-20-8380	i. Sex 7. Age (In yrs	() () () () () () () () () ()	r If Under 24 Hrs. 8. Da	ite of Birth onth, Day, Yea	9. Birth	place (State or Foreign
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Registrar

DHMH 17 Rev 1/2001

State

HOSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V COR KIM MD SINA |

31. Date filed (Month, Day, Year)

JUL 2 5 2005

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 21,200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) **Examiner** Ohn 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 KF Days Min Director USual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? ö Items 23£ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 4 Divorced 3 Widowed "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than ondary (0-12) College (1-4or 5+) er's Name (First, Middle, Last) ther's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Nu Town, State, Zip Code) HO MI 20c. Location permit. Pages Department of h Burial 2 Cremation 3 Removal from State Important: If ☐Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licenses once C any Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the ing, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Pina Cord **Physician** with complications resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROPRIATE BY MEDICAL EXAMINES Examine The law requires that the death certificate be executed detached for use as the burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 4 Unknown Diabetes, Endstage Renal Disease, Hypertension 2 🗆 No 3 Probably 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed Yes 2 No certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1-17 5 Pending Subject fell down steps 1 ☐ Yes X No death. 2X Accident investigation June 17, 2005 Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1214 Sheidan Ave. filled in by 4 Homicide at home Balto., MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

11

2005

DHMH 17 Rev 1/2001

Wolfe

32. Registrar's Signature

St.

BALTIMORE, MARY lANG

·04828 ı		1 - State Amend Item	State of Ma				-	•	
Physic	e e	Registrar 1. Decedent's Name (First, Middle, I		23008	Hillicate of D		. Date of Death Month		3. Time of Death
Physic /Medi Examir	cal	Richard Lee To			4b. City, Town, or I		luly	17 2005 4c. County of Deat	9:03 A M
Funeral Director		Franklin Squar 5. Social Security Number 6 220-52-3430		o (In yrs. last birthday) 55 Yrs.	Roseda If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, 2/27/19		re pplace (State or Foreign untry) laryland
death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent	imore	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 🏖 📆 No
th with the 23a or 28a	I Director	10e. Street and Number 3 Bowers Lane			10f. Zip Code 2107	'1	10	g. Citizen of What Co	untry?
ia	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	Was Decedent of His II Yes, specify Cuban 1 ☐ Yes 2 ☑ No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036 d 2 should be filed within 72 hours aff tilt and Mental Hygiens 127 is marked other than "nature!; or traumatic event, the Medical Exami	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) eman	tion uring most of working	1	6b. Kind of Business/	ore City
rland 212 Iland 212 Ila be filed withi fental Hygiene. rked other ther tic event, the N	To Be Co	17. Father's Name (First, Middle, La Robert Tillman				18. Mother's Name (i		laiden Surname)	ie oity
		19a. Interment's Name/Relationship	(Type, Print) ino/Daughter		ng Address (Street ar Bowers Lan			City or Town, State, 2 and 21071	(ip Code)
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item my injury or othe MAGE.		20a. Method of Disposition 1		20b. Place of Disponentery, cre Garrison	osition (Name of matory or other place Forest	7/26/		Oc. Location - City or Baltimore,	
Baltimore permit. Pages 1 Department of F important: if its eny injury or ot		21. Signature of Fundal Pervice Lic	ensee					pel Funera , Maryland	1 Home Inc. 21206
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O. Box ne death cert the attendin	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
cords, P. (w requires that the been signed by should be detact.)		Part II. Other significant conditions	s contributing to death b	ut not resulting in the u	inderlying cause giver	n in Part I.	23e. Did tob	acco use contribute to s 2∰No 3∏Pr	the cause of death?
	Completed						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of 2 No
of Vital Physician: rthis certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		nt 2 ER/Outpatie	nt 3□ DOA Other	4 Nuising Home	5 🗆 Resider	nce 6 Other (Spe	at scene
Vision C Attending P ortor: After by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no	found			es 2 XNo		w injury occurred eet and Number or Ru	unk
urs urs illec	ai Certi	4 - Homelde	building, et	ury - At home, larm, st c. (Specify) n motel ro	om			eet and Number or Au State) 8213 P Rosedale,	
To the Hosi within 24 ho To the Func	Medicai	one) 25 Medical Ex	aminer: On the basis of and manner sta	examination and/or in	vestigation, in my opi	inion, death occurred	at the time, da	te and place, and due	to the cause(s)
To To Con	Σ	29b. Signature and title of certifier 30. Name and address of person with	mpleted cause of	phus th (Item 23a) (Type	29c. License O.C.			July $18,\ 2$	
St.	ate	Tasker Z Greent 31. Date liled (Month, Day, Year)		111 : ar's Signature	Penn Stree	et, Baltimo	ore, Ma	ryland 212	01
Regist		JUL 2 5 2	005 Dans	JA A	acti				

			For State Registrar	State o	f Maryland / Depa	artment of H			ene g. No.2005	21.000
			Decedent's Name (First, Middle)	dle, Last)				2. Date of Death	1	3. Time of Death
	Physici /Medic		Mary Ther	ese Trai	nor			July 22	, ^{Day} 2005 Year	4:15 a M
	Examin		4a. Facility Name (If not institution		mber)		Location of Death		4c. County of Dea	
			Villa Assum			Towso			Baltim	Ore
	Funeral Director		5. Social Security Number 071-40-4564 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 17,	9. Bi 1927	rthplace (State or Foreign country)
	land ow		10a. State 10b. Count	у	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 1-1 sh	to	MD Balt	imore	Stevensor	1				1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a		1531 Greenspr	ring Valley	Road	21153			USA	
	er de:	Funeral	11. Marital Status	Armed Fo	rces?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
336	irs aft	by F	1 X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Giv	/8	1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
0-10	within 72 hours after death with the Maryland one. than 'natural', or items 23a or 28a-1 show ha Medical Eraini or mast bu notified at	ted	15. Decede	ent's Education	16a. Dece	dent's Usual Occupa	ation	. 1	6b. Kind of Business	VIndustry
218	ithin 7	Completed	Elementary/Secondary (0-12)	est grade completed) College (1	1-40r5+)	kind of work done of DO NOT use retired	during most of work ()	ing		
21	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar than "natural", or itams 23a or 28a-1 show evant, the Medical Evantion mast be notified at		17. Father's Name (First, Middle	(-24)	5+ Tea	acher	40.14.4.4.4.	45	Educati	ion
anc	ld be filed ental Hygia kad othar ic evant, t	Be c	John William				Mary	e (First, Middle, M Harkins		
Ž	2 should be and Mental Is marked aumatic ev	٦ ک	19a. Informant's Name/Relation		19b. Mailir	ng Address (Street a			City or Town, State,	Zip Code)
Ž	12 tra		Sr. Marion Sch	aechtel/re						
ore,	of Hei		20a. Method of Disposition 1X Burial 2 ☐ Cremation		20b. Place of Dispo	sition (Name of matory or other place	Θ)	Date 2	Oc. Location - City or	
<u>E</u>	Page ment ant: if ury or		`4 □Donation 5 □Other (Illcheste	er Cemete:	ry 07/2	5/2005	Illcheste	er, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		21. Signature of Funy all ervice	e Lights		2. Name and Addres	INU		r Funeral 21204	Home, Inc.
	- 8		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of	aused the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	B	1 0	anjer				Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a consequence of):					
В		_	Sequentially list conditions.	b. Director	or as a nonsequence of):					
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9	ertifica ling pt e as t		IF FEMALE:					_		
Вох	death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live b		Ectopic pregnancy			23d. Date of de Month	livery Day Year
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S,	es that igned b	by Ph	Part II. Other significant condit	ions contributing to de	eath but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be	ed b	Hypothyro	dism				1 🗀 Yes	2 X Uo 3□Pi	robably 4 DUnknown
Record	e taw requ has been ge 2 shoul	plet	Ostesporo	515				24a. Was an autopsy	24b. Were as	stopsy findings available completion of cause of
	The ate h page	Completed	Chronic Ob	structive	Pulmonary	Disea	se_	performe	ed? death? No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al Hospital:			26. Place of Deatl	(Check only one		
of	를 를 들	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date (npatient 2 ER/Outpatien of Injury 28b. Time of		4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
on	Attanding or death. actor: After by the funer	tion	1 XNatural 5 ☐ Pend		h, Day Year) Injury	Work	(? Yes 2 □ No	200. Describe now	injury occurred	
Division	r Attano er death ractor: by the	Certification:	3 ☐ Suicide 6 ☐ Could	I not be 28e. Place	of Injury - At home, farm, stre				et and Number or Ri	ural Route Number,
	tai or s afte al Dir ed in l	Cert	4 _ Aomicide	Duildir	ng, etc. (Specify)			City or Town,	State)	
	To the Hospitai or Attandin within 24 hours after death. To the Funeral Diractor: Att completely filled in by the fur	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the I Examiner: On the ba and mann	best of my knowledge, death asis of examination and/or inverstated.	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as a and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifi	di 1		29c. License			I. Date signed (Mont	
				In		DS	0623		67-22	-2005
	3		30. Name and address of person	who completed caus	e of death (Item 23a) (Type,	Print)	N. #1			-2005 UDZ1204
	-/-		31. Date filed (Month, Day, Year	n Gu, U	1D (SOS	Usler	D7, 44	05,10	WSON V	uncleod
	Sta Registr	-	JUL 25	2005	egistrar's Signature	Wed .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Year

9:30 PM

Birthplace (State or Foreign Country)

Whit

10d. Inside City Limits

1 Yes 2 No

WD91823

Approximate Interval Between Onset and Death

Day

2 No

1 TYAS

29d. Date signed (Month, Day, Year)

Year

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** imm leredith 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto laris limonium If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 D F Yrs 218-34 -7733 Aug. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show other treumetic event, the Medical Examiner must be notified at Director Princess Somersy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 2185 SA 3061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2□No USN 1 Yes 2 I If Yes, Give Year or Dates: 2 Married 1 Never Married Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: þ 3 Widowed 4 Divorced "natural" 9:30 р.ш. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "ne any injury or other treumetr. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Perc 2005 mead 19a. Inform t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pine Epoll Princess Anne Dr. lian husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State -28-05 ¹ 4 □ Donation 5 □ Other (Specify) Letro Comaton 21. Signature of Funer Service Licenses 22. Name and Address of Facility ITAM 1232 Midvalle, Dr. Jessup, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of beart failure. List only one cause on each line. Immediate Qause (Final disease of condition resulting in death) **Physician** END STAGE DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physiclan/Medlcal as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No detached the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be MEREDITH TIMM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Aiter 1 Natural 2 Accident Injury 5 Pending 2 🗆 No To the Hospitel or Attendl within 24 hours after death, To the Funerel Director: A investigation 1 Yes filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

2 5 2005

(Check only one)

29b. Signature and title of certifier

Registrar

29c. License number

43720

			1 - For State Registrar	State of M	arylar			nt of H		and M		giene Reg. No.	000	15	21:2	22
	Physici		1. Decedent's Name (First, Middle, La	si) //LLVMS	UN						2. Date of De. Month	ath Day		Year	3. Time br	A M
	/Medic Examir		4a. Facility Name (If not institution, give	e street and number,			4b. City	, Town, or	Location o	of Death			County of	f Death	1	
	LXuiiii		GOOD SAMARITAN HO	OSPITAL			B	ALTIM	ORE			r	ı/a			
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				<u> </u>			1	0d. Inside City	y Limits
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	ith the	Director	10e. Street and Number				10f. Z	ip Code				10g. Citi	zen of Wh	nat Coun	try?	
	ath w 23a	ral	1638 THETFORD R					2128					USA		1 6	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow any njury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 XYes 2 If Yes, Give Year or Dates:	No			edent of Hi ecify Cuba 2 XNo	spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	•		White,	an Indian, etc. HITE	
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	and 2 : salth ar n 27 is ser trau		DORIS M. WILLIAM			1638	THE	TFORD	ROAD	TO	WSON, N	1D 2	21286	5		
ore,	of Hear fitem		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Bamoval from State		Place of Disponentery created TANEY			8/4	D	ate	20c. Lo	cation - C	ity or To	wn, State	
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Baltimore,	permit. Departrimporta		21. Signature of Funeral Service Licer		_	8	521	LOCH	RAVEN	BLV		/SON	JNERA MD	L HO 212		. А.
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	s that pred b e deta	y PI	Part II. Other significant conditions of	ontributing to death I	out not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contrib	oute to th	e cause of de	ath?
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim on, in my op	ne, date and pinion, dea	d place, a th occurre	and due to the	cause(s) date and	and mani place, an	ner as st nd due to	ated. the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier	1111				9c. License			1			*	Day, Year)	
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16), /		30. Name and address of person who 5601 WUH MV	completed cause of	death (Iter	n 23a) (Type,	Print)	ทก	2123	35						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	29	ature	A.	alle								

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 11:20 A M ANDERSON 10 2005 ROLAND July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death FRIENDS NURSING SANDY SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 22 1917 7. Age (In yrs. last birthday) 100 M 2 □ F 011-12-4026 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Sandy Spring 1 Yes 2 No Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 17219 Quaker Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U. S. Government Personnel Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anderson Oscaria Jacobson W. Adrian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Spring, Md. Alice M. Anderson / Wife 17219 Quaker Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 S Cremation 3 ☐ Removal from State Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 7/11/05 Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Murie P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has To the Hospitel or Attending Physicien: After Director: / within 24 hours a To the Funerel D

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mentall Hyglene. Important: If time 27 is marked other than "naturel", or Items 23s or 28a-1 show any injury or other treumatic awant.

Physician

/Medical

Examiner

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the attending physician

Baltimore, Maryland 21215-0036

ortant: If item 27 is marked other than "naturel", or items 23s or 28a-1 show injury or other treumatic event, the Medical Exaction must be rediffied at a.

State Registrar

J. Klays, Mi 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Philip Dabe Olnoy MD 20832

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			1 - For State Registrar		rtificate of De			้ 2กกร	21.225
I			1. Decedent's Name (First, Middle, Last)			12	2. Date of Death		3. Time of Death
	Physici /Medio		William J. Allen				July 4,	2005 Year	5:10 P M
ز	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Lo	cation of Death	1	c. County of Dea	
			Southern Maryland		Clinton	Ulada-O4 U		rince Ge	
	Funeral Director		5. Social Security Number 6. Sex 577–18–8270	7. Age (In yrs. last birthday) M 2□ F 93 Yrs.		Hours Min,	B. Date of Birth (Month, Day, Yea Iay II, I	9. Bi	rthplace (State or Foreign country) th Carolina
			Usual Residence of Decedent			1	idy 11, 1	JIZ NOI	th carolina
	ırylan show	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ba-f	Director	Maryland Prince Ge	eorges Capitol					X Yes 2 No
	death with the Maryland ma 23a or 28a-f show	Dir	10e. Street and Number 1825 Nova Avenue		10f. Zip Code 20743			Citizen of What C	
	na 23	erai		12. Was Decedent Ever in U.S. 13.		anic Origin? (Speci		nited St	
9	after o	Fun	1 Never Married 2 Married	1 AYes 2 No	Was Decedent of Hispa If Yes, specify Cuban, M		can, etc.)	Black, Wh	ite, etc.
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<u>lar</u>	uld be Venta rrked rific ev	To B	James Allen			Estella	White		
Maryland 21215-0036	2 sho and I is ma		19a. Informant's Name/Relationship (Type		ng Address (Street and				Zip Code)
	l and fealth im 27			Bacon/daughter 4800		Street,			20781
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28a-f show many injury and the traumatic event, It a Modical Examiner must be notified at an once.		20a. Method of Disposition 1	emoval from Statecemetery, crei	matory or other place) National			Location - City or	
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к 68	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:						
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P. O.	that the de ned by the a detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)				
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ā	tal or A	Cert	4 Tromede	building, etc. (Specify)			City or Town, Sta	re)	
	To the Hospital or At within 24 hours after on the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examin	ician: To the best of my knowledge, deather: On the basis of examination and/or in	h occurred at the time, o	date and place, and	d due to the cause(at the time, date a	s) and manner a	s stated.
	o the ithin 2 o the omplei	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License nu			ate signed (Mon	
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	>		30 Name and d ss of person who con	mpleted cause of death (Item 23a) (Type,	Print)	5-13		-1 1/	
			12 WISEVSKEY	MIN. 12010 C	U) LINE	CEURO	e whe	out, a	2005' Ud. 2060 z
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	/Media				AILSTOCK,	JR	•					07	67	65	23	05 1	VI
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	pud &		Usual Residence of	10b. County		10c Ci	ty, Town or Lo	nontion								e City Limit	
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	ems c	Funeral	11. Marital Status		12. Was Decedent		J.S. 13.			ispanic Origin? n, Mexican, Pu	(Specify	y Yes or No	-	14. Race - Am Black, Wh		n,	
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ē,	s 1 and if Health itam 27 othar tr		20a. Method of Dis	sposition		20b. I	Place of Dispo	sition (Nan	ne of		Date	-		cation - City o	Town, State	8	
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Division	or Attendi after death. Director: A d in by the fu	Certification:	4 Homicide	determined	28e. Place of Inj building, et	c. (Speci	ome, tarm, sti fy)	reet, factory	r, office		281.	City or Tou	otreet and m, State)	d Number or F	ural Houte f	Vumber,	
_	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune		29a. Certifier	1 Certifying Phy	sician: To the best	of my kno	owledge, deat	h occurred	at the tim	ie, date and pla	ice, and	due to the	cause(s)	and manner a	s stated.		
	n 24 h	edical	(Check only one)	2 ☐ Medical Exam	iner: On the basis o and manner st	f examina	ation and/or in	vestigation,	, in my or	oinion, death or	ccurred a	at the time,	date and	place, and du	e to the caus	se(s)	
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier	//			290		number			29d. Date	e signed (Mon	th, Day, Yea	ir)	
			PCF	well W	L				D	30853			-4	18/02			
	5+1		30. Name and add	ress of person who c	-		m 23a) (Type,	Print)		Regima	ia/L	edical	Cris.	La Sa	lic bur	1: MY)
	Sta	te	31. Date filed (Mo	UL ^{av.} 1°2 20.		ar's Signa	ature	INTUI	00	igima	1 An L	earar	COM	100	E CARRO	u si	_
	Registi			INT 1 % 50	US Klosen	ر ر	x s	and s									

DHMH 17 Rev 1/2001

ALSTOUL, FRANK C.

AOL Maryland 21215-0036 Baltimore, Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elva Mae Byers July 15 2005 2:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Homewood Retirement Center Williamsport Washington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F Hours Yrs **Director** 214-16-1647 88 Aug. 7, 1916 Mary land Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or itams 23a or 28a-f ahov the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue Funeral 21795 USA 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo Soecify: Completed by 3XXVidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Inspector Manufacturer t of Health and Mental Hys 17. Father's Name (First, Middle, Last) 18. Mother's Name /First. Middle. Maiden Sumame! Be Obitts Prudence Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and important: If Itam 27 is n any injury or othar traun Jean Forsythe - Daughter 10 N. Conococheague St. Williamsport, MD 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Riverview Cemetery 4 □ Donation July 18,2005 Williamsport, Maryland 5 Other (Specify) 21. Signature of Funeral Service Osborne Hunerally Home, P.A. 425 S. Conococheague St. Williamsport, MD disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Shock, or heart Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown Part II. Other significant conditions gontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Division of Vital Physician: 25. Was pase referred to medical examiner? 26. Place of Death (Check only one) Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ٩ 1 ☐ Yes 2 No 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one 29b. Signature and title of cer 0 29d. Date signed (Month, Day, Year) wno completed cause of death (Item 23a) (Type, Print) 30. Name and 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_	State of Ma						-	_	DIE.	
			1 - State Registrar		,	•	tificate				00	05	21.220
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	4	3. Time of Death
	Physici /Medi				Garci	a Br	amao			July	9, 200	Year 05	2:00 A M
	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or i	Location of Death		4c. County	of Death	h
			4424 Chalfont Place				17.17		hesda		Montg		
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age	88 (In yrs. las	t birthday) Yrs.	If Under Months	Days Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da NOV • 4,	h y, Year)	9. Birth	nplace (State or Foreign untry) Cugal
	- 6		Usual Residence of Decedent							NOV . 4,	1910	101	Lugar
	nyland how		10a. State 10b. County		10c. City,	Town or Lo	cation	-					10d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Montgomer	у	Bet	hesda	1						1X Yes 2 □ No
	vith th	Dire	10e. Street and Number 4424 Chalfont Place				10f. Zip		017		10g. Citizen of V		•
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "neturel", or Items 23a or 28a-f show event, I're Medical Examinar must be notified at	Funeral Directo			i- II 0	40.1		208		7 11 1	USA/Por		
	ter de	-Lu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		13.	was Decede f Yes, spec	ent of His ify Cuban	panic Origin? (Spe , Mexican, Puerto	Rican, etc.)	14. Hac	e - Amei ck, White	rican Indian, a, etc.
036	ursa el', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes 2	X No	Specify:		Specify	Wh	ite
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7	ithin se.	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)				iring most of work	ng			
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anc	m 0 9	Be	Raul Cardozo Ressa	no Caraja					18. Mother's Name Joanna		Maiden Suman	10)	
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	nd 2 string at the tree	ľ	Vasco L. Bramao/So						Place, B				,p 00da)
ē,	a H m HD		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	e of	July	Pate 11,	20c. Location -		Town, State
Ē	Page nent c		1 ☐ Burial 2 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State			tan Cr				Alex.,	Virg	inia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic espece.		21. Signature of Juneral Service License	3000		22	. Name and	d Address	of Facility De V 2222 Washi	ol Fune	ral Hom	ie M	.W.
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			23a. Part. Enter the disease, or complications, or heart failure. List only on	e cause on each lin	the death. e.	Do not ent	er the mode	of dying,	such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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<u>=</u>		Con								perfor	med? c	death?	2 □ No
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:					26. Place of Death				
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Ö	tel or s afte el Dir	Cert	4 Hornicus	building, etc	. (Ѕрвсіту)					City or Tow	n, State)		
	To the Hospitel or Al within 24 hours after o To the Funerel Direc completely filled in by	edical	29a. Certifier 1 Certifying Phys	or. On the bases of	examination	dge, death and/or inv	occurred a restigation, i	t the time in my opir	, date and place, a nion, death occurre	and due to the o	ause(s) and ma late and place, a	nner as s	stated. to the cause(s)
	within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stat	ted.			License i			29d. Date signed		
	- 3-5		1/3 Krom	//				DO	0023600				2005
			30. Name and address of person who con	mpleted cause of de	ath (Item 23	3a) (Type, I	Print)				J		
			Bruce R. Kressel,	M.D. 214	1 K St	t., N	.W. #	707 V	Vashingto	on, D.C.	20037		
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State of Maryland / Department of Health and Mental Hygiene

					Olak	o i ivia	i y lai la				Death	Wortan 11	Reg. No.	2005	- ,	212	20
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	Examine	r 4e Fe		not institution, gi							4b. City, Town, or	Location of Dea	th 4c. (County of Dea	ith		
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П	Funeral		ial Security Nu 9-36-08		Sex 1 □ M 2 X 0		(In yrs. las	t birthday) Yrs.	Month	er 1 Year Days	If Under 24 Hr Hours Mir		rth ay, Year)	9. Bir	thplace ountry)	e (State or F Carol:	oreign
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	yland	10a. S		10b. County			10c. City, 1	Town or Lo	ocation						10d.	Inside City L	Limits
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Baltimore, Maryland 21215-0020	d othe	17. Fat		irst, Middle, Las	•						18. Mother's Na	me (First, Middle	, Maiden S	Surname)			
yla	Ments Ments arked attice	Do	ouglas	William	S						Louise	William	S				
Jar	2 shd end is m	1		me/Relationship							and Number or F		-	Town, State, .	Zip Co	de)	
<u>~</u>	end leasth m 27 her tr				yson /	daug	The second second				nt Road,			20706			
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in Modical Examiner must be notified at once.	21. S /g	natore of Fun	eral Service Lice	See	+10	1				ss of Facility Mo						0.1.0
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	Physician /Medical	Immed	liate Cause (F	inal	,		()							1	i L		
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	v requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the bunet-trensit letted by Physician/Medical Examiner.	Segue	ntially list con-	titions	b		ue to (or as								ь	wks.	
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o	let the death or d by the attend leteched for us Physician/	Part II.	Other signific	ent conditione o	ontributing t	o death but	not resultin	g in the un	nderlying	cause giv	en in Part I.	23b. Did	tobacco u	se contribute			
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<u>a</u>	entificet ector, p	25. Wa	s case referre	ory Fai	Lule						26 Place of De	ath (Check only		140		s 2 No	
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0	g Ph terth nerel		ner of Death	5 Pending		ate of Injury Month, Day		b. Time of Injury		28c. Injur Wor	y at	28d. Describe			,/		
<u> </u>	andin sath. or: Af he fu	2	Accident	investigatio	1	,		,,	М		Yes 2 □ No						
DIVISION	ital or Attanding P irs after death. al Director: After it led in by the funera Certification:	3 L 4 C] Suicide] Homicide	6 Could not be determined	286. PI	ace of Injury	/ - At home (Specify)	, farm, stre	eet, factor	ry, office		28f. Location (City or To	Street and . wn, State)	Number or Ru	ıral Ro	ute <i>Number</i> ,	
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	10			y Murth						oad,	Cheverly	, Maryl	and				
	State Registrar	2	e filed (Month,			egistrar'	2.4	Gos	will)						- A	

DHMH 16 Rev 6/95

1 - For State Registre	State o	f Maryland / Depa Cea	artment of Hea rtificate of De	alth and Mer e <i>ath</i>	ıtal Hygiei Reg.		24230
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/Medical	Juanita Brown			Ju	1y 5 2	005 Year	1:57 am
Examiner	me (If not institution, give street and nur		4b. City, Town, or Loc	cation of Death		4c. County of Death	
50:10	Arundel Medical	Center 7. Age (In yrs. last birthday)	Annapoli:	41 4 7 7 7 7 7 7 7 7	Date of Birth	Anne Arı	undel place (State or Foreign
I ullel at	6-7046 1□M 21XF	59 Yrs.			Month, Day, Ye.	946 Mars	ntry)
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and the state	10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Maryl 10e. Street a	and Anne Arundel	Annapol:	S 10f. Zip Code		100	Citizen of What Cou	
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titer death virities 23 of the result of th		edent Ever in U.S. 13.	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Specify	Yes or No-	14. Race - Ameri	
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To the state of th	ame (First, Middle, Last)			. Mother's Name (Fir			
should be so that it is a specific ave of partice a	obtainable				eth Wh		
	nt's Name/Relationship (Type, Print) n Brown (Son)		g Address <i>(Street and i</i> Silopanna				
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Till Method of the man	al 2□Cremation 3□Removal from t ation 5ੴether (Specify) Enton	State	gate Mem	. 7/8/0	5 An	napolis,	Mđ.
	of Funeral Service Licensee	22	. Name and Address of	f Facility	-	-	
	vy Gorgeen		n. Reese 8 21 West S	& Sons M t. Annap	Ortuar olis,	у, Р.А. Md. 2140)1
Snock, (nter the disease, or complications that corr heart failure. List only one cause on e	aused the death. Do not entrach line.	er the mode of dying, su	uch as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
/Medical Immediate C disease or co resulting in d	eath) a. Ca	rdiac arr	est				lhr
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S e e e e e e e e e e e e e e e e e e e	significant conditions contributing to de	eath but not resulting in the ur	iderlying cause given in	Part I.		o use contribute to the	
law requires law requires as been signe is 2 should be repleted by	Viaheres				-	2 No 3 Prob	ably 4 Unknown
NI RECORD The law requires that has been is page 2 should					24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
- 27	referred to medical		00	. Place of Death Ch	1 ☐ Yes 21 🗹 1		2□ No
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After this Ton		of Injury h, Day Year) 28b. Time of Injury	28c. Injury at Work?		Describe how in		,,
or Attending the death. Jiriston or Attending the death.	ent investigation		M 1 🗆 Yes	2 🗆 No			
DIVISION (18) Certification; 24 Waveling P (20) Marin (determined 288. Place	of Injury · At home, farm, streng, etc. (Specify)	et, factory, office	28f. L	ocation (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	1 Certifying Physician: To the	best of my knowledge, death	occurred at the time, da	late and place, and o	lue to the cause	(s) and manner as s	hated
edical (Check o one)	Medicel Exeminer: On the ba and mann	asis of examination and/or inv	estigation, in my opinion	n, death occurred at	the time, date a	and place, and due to	the cause(s)
29b. Signatur	and title of certifier		29c. License nur	mber	29d. D	Date signed (Month,	Day, Year)
•	James Kupped and	•	00021	5499		2/5/05	
30. Name and	address of person who completed caus	Malie.	Print)	61.	2	A 11	4.15
State 31. Date filed	(Month, Day, Year) 32. F	gistrar's Signature	TIGHWAY	suite	202	Ar nold	, MD 21012
Registrar	JUL 0 8 2005	bon & A	ment !				i i

05-04428 Joseph Blake RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2_Date of Death 36ay 1. Decedent's Name (First, Middle, Last) **Physician** Joseph Jared Blake /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Bowie Health Center Prince Georges Bowie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, NOV 13 9. Birthplace (State or Foreign **Funeral** Hours 219-11-7123 1⊠M 2□F Months Days Min 19 Nov 1985 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Maryland Prince Georges Upper Marlboro Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 Eton Drive 20772 USA or itams 23a 12. Wes Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Camp Counslor Patuxent Recreation 12th <u>2yrs</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Guy Blake Andrea Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Guy B. Blake (Father) β301 Eton Dr. Upper Marlboro, Md. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages Adams U, M, Church 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. ö * 4 ☐ Donation 5 ☐ Other (Specify) 7/9/05 Lothian, Md. Cemetery 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Larry & Reese MONY83 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician My me disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□ Unknown 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

✓es 2 □ No page 2 autopsy perform ed? certificate Yes 2 No Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 2 No 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Deceased driver of mutagely s after dec. 5 Pending investigation 1 Natural 2050PM 2 X No 4/30/05 1 TYes 2 Accident Strulle van 6 ☐ Could not be 28f. Location (Street and Number or Rural Royte Number, City or Town, State) 2+ 301 Sibon 3 🗒 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Bowie, MD VOCC Forest Dr. To the Funerai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 onel and manner stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) O.C.M.E. July 1, 2005 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 R. 0 32. Regitrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 8 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2130 2005 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Yeady Nie EDWARD vistiold Memorial JOMERSE 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year 08-01-10 **Funeral** Birthplece (State or Foreign Country) Days 1□ M 2**X**F Months 65 Yrs Director MD Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic avoid to the statement of the sta 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Completed by Funeral Director Domerset Street end Number 10f. Zip Code 10g. Citizen of What Country? 21817 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. l ☐ Yes 2 1 No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo 3 ☐ Widowed 4 ☐ Divorced 13 ack 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 24 crdve -nspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be John ဥ enry laylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) risfield ИD 21817 P.O. Box 403 21. - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WARD lown 22. Name and Address of Facility AHONG, E. Ward F Name and ... Athony 5. 1.29 Hampden ing, such as car 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPS15 Examiner Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physiclan/Medical Due to (or as a sunsequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to tha cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ASCVD Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? TYPE I DM completion of cause of death? 2 No 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 20 No 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) aral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral C 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha I

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 16 Ray 6/95

JUL 1 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geren & Specie

29c. License number

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

9/2005

29d. Date signed (Month, Day, Year)

D 48098

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DaZ U U.5 **Physician** 10,2005 Wanda Ethel Bond July 2:45p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Care Elkton
If Under 1 Year If Under 24 Hrs. Cecil 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖳 F Yrs. Director 91 March 21,1914 407-30-2321 WV Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director FLOkeechobee Okeechobee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 4489 S.E. 441 34974 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ð 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) 8 Owner/Operator Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David B. Grubb Janie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 s tment of Health ar tant: If Item 27 is jury or other trau Marcella Hawkins/daughter 58 Piney Ridge Lane, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of important: ff any injury or once. R.A. Ferris, Inc. July 13,2005 West Chester vice Licensee 22. Name and Address of Facility Pennsylvania Andrew G. Gee Funeral Home 9 E. Main St., Elkton, the mode of dying, such as cardiac or respiratory arrest, 259 23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SIZEMS7 Physician UNTREATED Unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed D signed by the attending physician and deed be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been sig., page 2 should b 1 Yes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2□ No 1 TYes 25 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural s after de-of Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not b 3 ☐ Suicide 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year) rson who completed cause of death (Item 23a) (Type, Print) Rd. New Castle. 81 Ston hurchmans 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year JAMES S. BOLDEN /Medical May 31 2005 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months Director 577-30-0701 81 July 23, 1923 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland | Prince George's XX Yes 2 □ No Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 28th Street Apt#5 20712 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No þ Specify: 3¥¥Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other treumetic event, The Medic once. Ginn's Office Supply Co. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Industry (Retired) 9th Grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame, James S. Bolden Mattie Hawkins Bolden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 -B- Steffey Street Staunton, VIrginia 24401 Cathy Crawford (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Resurrection Ceretery June 8, 2005 Clinton, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc.

N. F. Machineton, D.C. 20019 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Left Gan grenous fort **Physician** 5/15/05 /Medical Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): anding physician and use as the burial-transit requires that the death certificate be executed tuckonpois Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 ☑ No 2**X** No the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes X No M Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending hours after death. Accident investigation 1 ☐ Yes 2 ☐ No Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mathalie Moncisse 20060443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4C 20912 7600 CARROLL AUENCLE to KOMO PONK MA Nathoure NARCISSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Day 2. Date of Death Month Play Year Year

Physician /Medical **Examiner Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examples in must be notified at once. Be Completed by Funeral Director Physician /Medical Examiner Examiner Division of Vital Records, P.O. Box 68760, Physician/Medical Completed by To the Hospital or Attanding Physician: The lav within 24 Hours after death.

To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2: Medicai Certification: To Be

Churlotte Corporter

1 - For Stete Registrar	State of Ma	arylaniu	-			Death			Reg. No	2005	21.22
Decedent's Name (First, Middle, Last								2. Date of Dea	th Day	Year	3. Time of Dea
Charlott	e C. Bicke	ett	·····,					July	4	2000	
4a. Facility Name (If not institution, given Doctors Community				4b. City, Lanl		Location	of Death	ı		County of De	
5. Social Security Number 6. S 579-20-1094	ex 7. Ag	e (In yrs. las: 85	t birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day April 2	Year)	9. 8 920 Vi	rthplace (State or For Country) rginia
Usual Residence of Decedent		1									
10a. State 10b. County Maryland Prince G	eorge	10c. City, 1	Town or Loo lphi	cation							10d. Inside City Lin 1X Yes 2 ☐
10e. Street and Number 9200 Edwards Wa	y #212			10f. Zip	Code 20783	3				zen of What C	-
11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		1	Vas Dece Yes, spe				ecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: B	
15. Decedent's Ed (Specify only highest gra	lducation	1	16a. Deced	lent's Usu kind of wo	ai Occupa	ation during mos	st of worki	ing	16b. Kir	nd of Busines	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5		life. ۵ Archi		se retired)				Privat	e
17. Father's Name (First, Middle, Last) Robert Carpenter							ers Name	e (First, Middle, atum	Maiden	Sumame)	
19a. Informant's Name/Relationship (Kathleen Wood/Dau								Al Route Numbe			Zip Code) 20747
20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □		20b, Plac	e of Dispos etery, crem	sition (Na	ne of	-				cation - City o	
'4 □ Donation 5 □ Other (Specify	v)	Harm	A -					3,2005		ndover	
21. Signature of Funeral Service Licer	7//2	holl				s ol Facili	by Poj 55. Fo	pe Fune 38 Marli restvil	ral poro le, l	Homes Pike MD. 20	0747
23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	the death, I	Do not ente	er the mod	le of dyin	g, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	ARD1	ORE	SPI	RAT	ORY	A	RREST			Onset and Death
Sequentially list conditions.	b. — Due to (or as	CON	GES	TIV	E 1	tea	RT	FAIL	DRE		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	PNE	,	2110							
resulting in death) Last	Due to (or as	a consequen	ice of):	10(1	1						
`	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3 🗌	Ectopic pr Other (sp					2	3d. Date of de Month	olivery Day Year
Part II. Other significant conditions of				derlying o	ause give	en in Part I		23e. Did to	bacco u	se contribute t	o the cause of death
	L FIBRI		101			_		1 🗆 Y	es 2	№ 0 3 🗆 Р	robably 4 Unkno
HY F	ERTEN	SION						24a. Was a autops perform	sy med?	24b. Were a prior to death?	utopsy findings availa completion of cause s 2 \sum No
25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			
1 ☐ Yes 2 ☐ No	Hospital: 1. Impatie		/Outpatient			4 140	irsing Hor	ne 5 Reside	ence 6	□Other (Spe	ecify)
27. Manner of Death 1	28a. Date of Injur (Month, Day	ry Year) 28	b. Time of Injury	М 2	8c. Injury Work 1 🔲 ۱	at (? (es 2 🗌		28d. Describe h	ow injury	occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	, farm, stre	et, factory	, office		2	28I. Location (Si City or Town		l Number or A	ural Route Number,
29a. Certifier Certifying Ph	ysician: To the best oniner: On the basis of and manner sta	examination	dge, death and/or inv	occurred estigation	at the tim	e, date an inion, dea	d place, a	and due to the c	ause(s) a	and manner a place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier	2)			290	. License	number		2	9d Date	signed (Mon	th Day Year)

To the Hospital
Within 24 hours
To the Funeral
Completely filled
Officer of the Medical Off

SURESHKUMAR MUTTATH 4203 QUEENSBURY RD. BYATTSUILLE, MD 20781
31. Date liled (Month, Day, Year)

JUL 1 2 2005

Bleen & Jane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7/11/05

D 00 58290

			For State	State of Marylar		artment of H		d Mental Hy		005	21.226
			Registrar 1. Decedent's Name (First, Middle, Last)		inoate of	Douin	2. Date of D	eath		3. Time of Death
	Physici		MORRIS ALLISON BE	EALLE, JR.				July	9 Day	2005	5:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D		4c. Cou	nty of Deeth	
			Crescent Cities Co	enter		River					orge's
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year Months Days		Min (Month, D	irth lay, Year)	9. Birthp Cour	place (State or Foreign htry)
	Director		209-18-1605 Usual Residence of Decedent	79	Yrs.			Oct. 18	8, 1925	Holl	ywood, FL
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	Od. Inside City Limits
	Mary if eh	ţō	MD Prince Ge	orge's Ne	ew Carr	ollton					1∭Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	th wit		5705 83rd Place			2078	4		U.	S.A.	
D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f ehow any injury or other traumatic event, it e Modical Examination and item and the notified at ance.	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces?1 ∑Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, P	? (Specify Yes or N luerto Rican, etc.)	E	Race - Americ Black, White,	
213-0030	ral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							ite
ב	natu	Completed	15. Decedent's Edi (Specify only highest grad	lcation le completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of	working	16b. Kind o	f Business/In	dustry
7	withir ene. than	E D	Elementary/Secondary (0-12)	College (1-4or 5+) 2		nician	u)		Feder	al Avi	ation Adm
В	filed Hygir other	C	17. Father's Name (First, Middle, Last)		1001	111101011	18. Mother's	Name (First, Middle	1		
yland	id be ental ked c	ToB	Morris Allison Be	ealle. Sr.			Esmer	alda Wal	lton		
_	shou ind M s mar umat	}	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street	and Number o	r Rural Route Numi	ber, City or To	wn, State, Zip	Code)
Man (and 2 alth a 127 is		Patricia Bealle,	Spouse	5705	83rd Pla	ce, Nev	Carroll	ton, Ma	ryland	20784
o e	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	20b.	Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	Date	20c. Locatio	on - City or To	own, State
Ĕ	Pag ment ant: I		*4 □Donation 5 □ Other (Specify,	Met		an Crematio		/13/2005			
baitimor	permit. Depart Import any inj once.		21. Signature of Funeral Service Licens	99				Gasch's lawer were and the second sec			
F	7 :		23a. Part1. Enter the disease, or comp	lications that caused the dea						110, 1	Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acute Myoc Due to (or as a conse		Infarcti	.on				Onset and Death
Į.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	quence of):						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
Š	e exe ian a urial-l		resulting in death) Last	Due to (or as a conse	quence of):						
8/60,	ate b	dicai	•	d							
O. Box o	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of delive	ery Day Year
T.	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause gr	en in Part I.	23e. Did	tobacco use c	ontribute to th	ne cause of death?
cords	w require: been sig should b		Hypertension; At	rial Fibrilla	tion			_ 1□	Yes 2∭ No	3 Prob	ably 4 Unknown
Keco	e law has b je 2 si	Completed						perf	ormed?	death?	psy findings available mpletion of cause of
VITAL	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only	21	1 🗌 Yes	2 No
	Physician: this certificant	0 B	evaminer?	Hospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Ott		ng Home 5 ☐ Res		Other (Specifi	v)
0	iding Physician: th. : After this certifica funeral director, p	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju			how injury oc		
0	r Attending Fer death. rector: Atter by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Buy rour)	in quity		Yes 2□No				
DIVISION	el or Attenes safter death Il Director: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, str ify)	reet, factory, office			(Street and Nu own, State)	imber or Rura	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my	me, date and p opinion, death o	place, and due to the occurred at the time	cause(s) and , date and place	manner as si	tated. the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	15		P who I'm			D25	079		Ju1y	12, 20	005
	(00		30. Name and address of person who o								
	- Eu		Don H. Yablonowit 31. Date filed (Month, Day, Year)	z, M.D. 7404 32. Registrar's Sign	Ececui	tive Plac	e #502	, Lanham-	Seabroc	ok, Mar	yland 2070
	Sta Regist		JUL 1 2 2005	see the d	and .						
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N	,		rtificate						2005	2123
	Physici	an	Decedent's Name (First, Middle,	,						2.	Date of Dea	th Day	Year	3. Time of Death
	/Medi	al	HAROLD SIMION BO				1 0: 3		1		July	-) 900Z	
	Examir	er	4a. Facility Name (If not institution,	give street and numbe	1 10-	11	46. City, 1	own, o	r Location of E	Death			County of Death	
	Funeral		5. Social Security Number	<i>DG/ / KCI / CG</i> . Sex 7. A	Age (In yrs. Ia	st birthday,	If Under		If Under 24		. Date of Birth	,	VICONI 9. Birth	place (State or Foreig
	Director		578-09-9236	1 ∑ M 2□F	87	Yrs.	Months	Days	Hours	Min.	(Month, Day)9-17-	(Year) 1917	CAN	intry)
	D .		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or L								404 1-14-05-11-5
	shov	7		T OFFE										10d. Inside City Limits 1 ☐ Yes 🏌 ☐ No
	within 72 hours atter death with the Maryland ene. Than "natural", or items 28a or 28a-f show na Madical Extrating to use the collised at	by Funeral Director	FL CHAR	LOTTE	INGI	LEWOOI	10f. Zip	Codo			1.	IOa Citia	en of What Co	
	with with	ā		(TE				3422	n /.			rog. Citiz		
	ms 23	era	6300 BUNTING LAN	12. Was Deceder	nt Ever in U.S	i. 13.	Was Decede	ent of H	ispanic Origin	? (Specif	v Yes or No-	1	US. 4. Race - Amer	
	or iter	Ē	1 ☐ Never Married 2 Marrie	Armed Forces			If Yes, spec	fy Cuba	an, Mexican, F	Puèrto Ric	can, etc.)		Black, White	, etc.
	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2	X1 No	Specify:				Specify: W	HITE
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i	within sne. than	ш	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	SALE		,)	TNO MA	TEDTAL C
	12 should be filed within hand Mental Hygiene. 7 is marked other than "iraumatic evant, the Max		1 Z 17. Father's Name (First, Middle, La	ıst)			DALL	DITAL		Name (F	irst, Middle,		OING MA	IERIALS
	id be ental ked c	To Be	SIMION ALEXANDER	BOWMAN					MAUDE				,	
	nd M mar mat	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street				r, City or	Town, State, Z	ip Code)
	and 2 salth a n 27 is		BETTY BEIRLE - D	AUGHTER		31809	BEIR	LE I	LANE F	PARSO	NSBURG	. MA	ARYLAND	21849
	itam itam	1	20a. Method of Disposition			ice of Dispe	osition (Nam matory or ot	e of		Date			ation - City or 1	
	Pages nent of I ant: If its ary or of		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Bonation 5 ☐ Other (Spe		e	-				-12-	2005 I	ELMA	AR, DELA	AWARE
	permit. Pages I and 2 should be tiled within 72 hours after death with the Maryla Department of Health and Mental Hygiens. But a properties if item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item Maryleal Examinations to the marked at any Injury or other traumatic event, it is Maryleal Examinations to the marylead and page.		21 Signature of Funeral Service Li	ensee 1		2	2. Name and	Addre	ss of Facility	BOUND	S FUNE	RAL	HOME,	INC.
	20529		Jame /	Spell	7	7	U5 EA	ST	MAIN SI	KEET	, SALIS	BURY	,MARYL	AND 21804
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caus nly one cause on each	ed he death, ne.	Do not en	ter the mode	of dyin	ng, such as ca	rdiac or re	espiratory arr	est,		Approximate Interval Between
1	hysician	Ų,	Immediate Cause (Final disease or condition resulting in death)	_a pne	mor	Ma								Onset and Death
	/Medical Examiner		resulting in death)	1	as a conseque	,	_	•						1.5
		<u>.</u>	Sequentially list conditions,		9 COV									woughs
	ted	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		oraci'c	A	rdic !	Sing	2474	\sim				months
	executed and al-transit		that initiated events resulting in death) Last	U	as a conseque		1310	3	- P	,				11.6011110
	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	aiE												
	urticat g phy as the	edic		- u.								_		
	eath certific attending pl	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pre	anana	,			2:	3d. Date of deli	very
	ne deal the att hed fo	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant 9☐Unknown	at time of dea		Other (spe		<u> </u>				Month	Day Year
	that the di ed by the detached	Physician/Medical	9 Unknown											
	signed d be det	þ	Part II. Other significant condition	s contributing to death	but not resul	ting in the u	inderlying ca	use giv	en in Part I.					the cause of death?
	w requir been si should	ted								_	1 L Y	es 2 🗆	No 3 ☐ Pro	bably 4 20nknowr
	elaw hasb ye2si	Completed									24a. Was a autops	sy	prior to c	opsy findings available ompletion of cause of
		S									perfor	ned? 2 No	death? 1 ☐ Yes	2 🗆 No
į	Physician: The this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Oth	05		Check only or			
	를 를 급	. To	1 Yes 2 No 27. Manner of Death	1 La Inpa		R/Outpatie 28b. Time o		oth lc. Injur	4 🗆 (40)3)		5 Resident		Other (Spec	ify)
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	Attandi ar death. ractor: A by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of I	njury - At hor	ne, farm, st	reet, factory,				Location (S	treet and	Number or Ru	ral Route Number,
		Certification:	4 Homicide determin	building,	etc."(Specify)		,				City or Tow	n, State)		
	To the Hospital or Attan within 24 hours after deatl To tha Funeral Diractor: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the bes	st of my know	ledge, deal	h occurred a	t the tin	ne, date and p	olace, and	d due to the c	ause(s) a	and manner as	stated.
	he Ho in 24 in ha Fu pletely	Medical	(Check only 2 Medical Ex	caminer: On the basis and manner	of examination	on and/or in	vestigation,	in my o	pinion, death	occurred	at the time, d	late and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.0.0	1				e number		2	9d. Date	signed (Month	Day, Year)
	-)		J. 12. KD.YU	A DVIVE	2								1 11 / 1/	

State

Registrar

& Sparke

Salisbury, MD

21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. A. Reza Jall' 100 East carroll st

31. Date filed (Month, Day, Year)

JUL 1 2 2005

32. Project as Signature

Physic	ian	1 - For Amended # 1. Decedent's Name (First, Middle, Last) Mary Verllow			artment of F rtificate of		d Mental Hy 7/12/05 2. Date of D Month July	Reg. No		21, 238 3. Time of Death 6:15 A M	
/Med Exami	ical	4a. Facility Name (If not institution, give s Gladys Spellman Nu	street and number)	er	4b. City, Town, o	or Location of D			County of Beat		
Funeral Director		5. Social Security Number 6. Sex	7. Age (II	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	8. Date of 8 (Month D	irth (av. Year) 927	9. Bird Cha	nplace (State or Foreign unity) ries Cty, M	
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State Maryland 10b. County Prince G	eorges	C. City, Town or L Largo	ocation					10d. Inside City Limits 1 Yes 2 No	
with the 3a or 28a	i Direc	10e. Street and Number 13019 Peyton Drive			10f. Zip Code 207	44		10g. Citizen of What Country? United States			
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-? show other treumatic event, the Madical Examinar must be notilised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	lo-		s. Race - American Indian, Black, White, etc. Spe R.J.ack	
in 72 ho	Completed	15. Decedent's Edu (Specify only highest grade		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Benefits Administrator			king		nd of Business/Industry eral Government	
Maryland 21215-0036 td 2 should be filed within 72 hours all tth and Mental Hygiene. 27 Is marked other then "natural", or treumatic event, the Wadical Exam	Be Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		Bene	tits Admi	18. Mother's	Name (First, Middl Tascoe			, C. L.	
Aaryla 2 should b 2 should b and Ment 1 marke reumatic	2	Eugene Lee 19a. Informant's Name/Relationship (Ty Robert O. Barnes,	rpe, Print) Sr.	ng Address (Street and Number or Rural Route Numb Peyton Drive, Largo, Md							
Baltimore, M permit. Pages 1 and 2 Department of Health Important: if tiem 27 any injury or other tre once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		20b. Place of Disp			/12/2005	20c. Lo	dover, l	Town, State laryland	
Baltir permit. P Depertme Importan any injur		21. Signature of Funeral Service Licens	Timmon		2. Name and Address pe Funera		s, P.A. e, Forest	-111	o Md '	20747	
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate and cer	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury	Due to (or as a c	onsequence of):	Failure					Interval Between Onset and Death	
cords, P.O. Box 68 requires that the death certificate been signed by the attending planted by the detection of should be detached for use as the control of the second o	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of a 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y			23d. Date of del Month	ivery Day Year	
rds, P. quires that to a signed by ald be detacted.	ρ	Part II. Other significant conditions con Respiratory Failu		ot resulting in the	underlying cause gr	ven in Part I.			**	the cause of death?	
Reco	Completed	Septicemia					24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were au prior to death?	itopsy findings available completion of cause of	
Vitalician:	Be	25. Was case referred to medical examiner?	Hospital:		0#		Death (Check only	one)			
Of Physical Prithis of Prail dir	7: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie	ALL SEL DON	4(£) (40) 31	ng Home 5 ☐ Re			cify)	
Division of Vital Records, To the Hospitel or Attending Physician: The law requires t within 24 hours effer death. To the Funerel Director: Affer this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s	M 1	Yes 2□No	28f. Location	(Street ar		ural Route Number,	
Hospite 4 hours Funerel ely fillec	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sicien: To the best of r ner: On the basis of ex and manner stated	amination and/or i	th occurred at the t nvestigation, in my	me, date and popinion, death	place, and due to the	e cause(s e, date and) and manner as d place, and due	stated. to the cause(s)	
To the within 2 to the complet	Me	29b. Signature and title of certifier	SOFE.	>	D002	se number 26024			te signed (Mont. Ly 6, 20		
y c	tate	30. Name and address of person who collecter Miles, M.D. 31. Date filed (Month, Day, Year)		ndover Ro		F, Lan	dover, Mi	20	785		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Baddour Jeanette Hanna 2:00 P M July 10, 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Owings Calvert 1055 Tiffany Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country)

Jerusalem 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 🔀 F Months 79 280-56-5637 Director May 10, 1926 Usuet Residence of Decedent the Manyland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Itam 27 is marked other than "natural", or Itams 23e or 28e-f ahow other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Calvert 1055 Tiffany Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 Tiffany Park 20736 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 □ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ibrahim Hawit Malakeh Baddour ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18925 Sherbrook Ct. Owings, MD 20736 Raja Hawit, MD (brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 14 permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2005 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary Goff 8125 Southern Maryland, Blvd. Owings, MD 20736 J. 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PHOMA Immediate Cause (Final months **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, ed by the attending physician detached for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes Division of Vital Records, P.O. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe cirrhosis l ever 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 20 Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Mannes of Death 28b. Time of After or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funaral Director: / the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) m. D 2005 11 prin cause of death (Item 23a) (Tp). Print) 30. Name and address of person who 76d., MD. 20678 \$1050.ta 32. Registras Signature 31. Date tiled (Month Day, Year) State JUL 1 2 2005 D Registrar

	•	For State Registrar	State of Maryland /	•	nt of Health and te of Death		iene g. No. 200	21,21,
Physici /Medio Examin	al	Decedent's Name (First, Middle, Last, Charles Charles Aa. Facility Name (If not institution, give Corsica Hi	Louis		er ,,Town, or Location of Dea entreville	2. Date of Dea Month 0 7	09 2005 4c. County of Dea	
Funeral Director		5. Social Security Number 6. Se 214 13 8987	7. Age (In yrs. last		er 1 Year If Under 24 Hr	8. Date of Birth (Month, Day 09	Year) 9. Bir	thplace (State or Forei buntry) aryland
the Maryland r 28a-f show notified at	Director	10a. State 10b. County Md Queen Al 10e. Street and Number			sonville	1	0g. Citizen of What C	10d. Inside City Limit 1 Yes 2 □ Nountry?
d 2 should be filed within 72 hours after death with the Maryland than dheath Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at	by Funeral D	200 Ryans . 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give		617 edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 25th Specify:	Specify Yes or No- rto Rican, etc.)	U.S. 14. Race - Ame Black, Whit	
within 72 hour ene. than "natural" te Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	6a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of wo use retired)	orking	16b. Kind of Business	/Industry
should be filed within nd Mental Hygiene marked other than 'matic event, it e Mental Count, it e Mental C	To Be Co	17. Father's Name (First, Middle, Last) Charles E. (19a. Informant's Name/Relationship (Ty	Cooper		18. Mother's Na	me (First, Middle, I	ton	
permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tones		Martha Cheers 20a. Method of Disposition 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State 20b. Place ceme Mary	of Disposition (Natery, crematory or Yland Ve	ville Rd. Come of other place) eteran's 07 and Address of Facility East Dover	/14/05 Eric L.	20c. Location - City or Beluh i Dashiel	Town, State Maryland L F.S.
ate be executed Wedical Washington and We burial-transit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	9St,	Approximate Interval Between Onset and Death				
e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1				23d. Date of de Month	ivery Day Year
as been signed by th 2 should be detache	ρ	Part II. Other significant conditions co	htributing to death but not resulting	g in the underlying	cause given in Part I.		pacco use contribute to	the cause of death?
ate h page	Completed	Gastin mais					y prior to death?	utopsy findings availa completion of cause 2□ No
S E	Certification; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigation		Outpatient 3 D D. Time of Injury			e) Ince 6 Other (Spe	cify)
ta i e	fic	3 Suicide 6 Could not be determined	City or Town	reet and Number or Ri , State)	ural Route Number,			
to the trapping of which is a feet of the within 24 hours after death. To the Funeral Directors After the completely filled in by the funeral	ledical Certi	29a. Certifier Certifying Phys	picien. To the best of true:	dee deeth -	To the best of my knowledge, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred diagnost stated. 29c. License number 725433			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Bong Sun Choi July 6, 2005 6:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mariner Health of Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F 89 Vrs Director 212-29-9779 Oct. 20, 1915 Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral, or items 23a or 28a-f show Extroller out the notified at 1 ∰Yes 2 ☐ No MD Montgomery Potomac Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Korea 9213 Cambridge Manor Court 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify þ Asian a Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Don Ho Choi Hak Ja Hwang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Young Hee Hwang, Daughter 9213 Cambridge Manor Court Potomac MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory July 9, 2005 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Hines-Rinaldi Funeral Home, Inc. Ma 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖫 No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown been sig Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dysphagia has autopsy performed? page certificate 2 🔯 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other 1 ☐ Yes 2 No 2 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19609. C July 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road Ste. 202 Gaithersburg, MD 20878 Raman Tuli, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State maste) Registrar

			1 _ State	State of Maryland / [•	tment of H			-	000-	
_			Registrar 1. Decedent's Name (First, Middle, Last)		Oen	meate of L	zeati i	2. Date of De	Reg. No.	2005	3 Time of Deads
	Physici		. ,,	mag Comnot				Month	Day	Year 2005	M
	/Medic Examin		4a. Facility Name (If not institution, give str	mas Cornet		4b. City, Town, or	Location of Death	July		County of Death	7:45 A
	Examin	EI	Homestead Manor	,		Dentor				Caroli	ne
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign ntry)
	Director		171-07-5455	^{M 2□ F} 96	Yrs.	Months Days	Hours Min.	(Month, Da	27. 1	908 Peni	nsylvania
	2		Usual Residence of Decedent								
	thow thow	_	10a. State 10b. County	10c. City, Tow	m or Loc	ation					10d. Inside City Limits
	B-f-	cto	Pennsylvania Lanca	ster La	anca	ster					1 ☐ Yes 2 🔯 No
4	0 or 26	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Cou	ntry?
4	239		1516 Esbenshade			17601					es of Amer
+	tame tame	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or Ni Rican, etc.))-	 14. Race - Americal Black, White, 	
9	or i	by Fi	1 Never Married 2 Married	1 ▼Yes 2 □ No If Yes, Give	1	☐Yes ¾ ☐No	Specify:			Specify:	
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	ed o	Be c	George A.	Cornot				Mae C			
5	mark matter	ç	19a. Informant's Name/Relationship (Type		b. Mailing	Address (Street a	nd Number or Run				p Code)
Maryiand	d 2 s th an th an tren tren		Janet M. Parks								and 2162
שׁ .	Peges 1 and 2 should be lied within 72 nouts after death with the marylend aneat of Health and Menial Hygiene. Instit if liem 27 is marked other than "natural", or itame 23a or 28a-f show ant: if liem 27 is marked other than "natural", or itame 25a or 28a-f show arry or other treumatic event. It is Modical Evacultar truet be notified at		20a. Method of Disposition	20b. Place of	of Dispos	ition (Name of		Date		cation - City or To	
altimore,	nt of		1 ☐ Burial 2 ☐ Cremation 3 ☑ Re	moval from State St.	JOSE	ph New	9)				
	rithen in P		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licenses	Catho	olic	Cemete Name and Addres	ry 7/16	/2005	_Lan	caster	•
ä	permit. Pege Department o Importent: If any Injury or once.		* * Sucosta O	Moore -		ore Fur	neral Ho	ome, P	.А.		21629
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			shock, or heart failure. List only one	e cause on each line.					11031,		Interval Between Onset and Death
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	cate be executed physicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):						-
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ָ אַ	death certific e attending p id for use as f	/Me	IF FEMALE: N /A	ic. If yes, outcome of pregnancy						23d. Date of deliv	100/
ž 200	atten for u	lan	in the past 12 months?	1 Live birth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)			'	Month	Day Year
	he d	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	0	Othor (speedily)					
ב י	thet the death hed by the atter detached for u	by Physician/M	Part II. Dther significant conditions cont	ributing to death but not resulting	in the un	derlying cause give	n in Part I.	23a. Did	tobacco u	se contribute to t	the cause of death?
Records,	signed be del	d b						1 🗆	Yes 2	∃No 3 □ Pro	bably 4 Unknown
Ö	The law requires ste has been sign bage 2 should be	Completed						040 1460		OAh Wasa sut	as au findings quallable
ě	has has	mp						24a. Was		prior to co	opsy findings available empletion of cause of
<u></u>	i: The							1 ☐ Yes	2 🖪 No	1 ☐ Yes	2 🗆 No
or vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		aCI DOA Othe	26. Place of Deal				A
5	Phys this al dir	5	T Tes 2 INO	1 Inpatient 2 ER/O		3L DOA	4 Nursing no				ity) Assetd Lin
Ę		on	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Time of Injury	28c. Injury Work	(?	28d. Describe	now injut	y occurred	
Division	tor	cat	2 Accident investigation 3 Suicide 6 Could not be	One Discontinuo Abbarra			Yes 2 □ No	Off Leastion	/Ctroot no	d Number or Bus	m / Pauta Number
₹	F 6 F C	Certification;	4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	iarm, stre	ет, тастолу, опісе			wn, State		al Route Number,
_	To the Hospitel or At within 24 hours efter of To the Funerel Direct completely filled in by		200 Codilion ATT Continue Ct	injury. To the heat of multiple			a date == 2 1	and division of			-101-4
	Hos Hos Func Func tely f	edical	(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination a	ge, death ind/or inv	occurred at the tin estigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time	cause(s) , date and	and manner as : I place, and due i	stated. to the cause(s)
	thin 2 the mplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d Dat	te signed (Month,	Day Year)
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			malinda 8				05325	>	'/	14/2	205
			30. Name and address of person who cor					4. 6	21	-5	
			Melinda Butto 31. Date filed (Month, Day, Year)		m A	ne x 10	stor	WO	216	رد	
	St: Regist	ate rar	and the same of th	32. Registrar's Signature	· ·						
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			For State Registrar	State of Marylar		artment of H			giene eg. No 2005	21.21.3
			Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th	3. Time of Death
	Physici: /Medic		Eva	Courtney				July 7,		5:35 PM M
	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Deat	th	4c. County of De	
	Funeral		5. Social Security Number	0/10/ 1/10/10/ (3. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	SDU/Y If Under/24 Hrs	8. Date of Birth	Wicon 9.B	
	Director		214-18-2918	1□M 2 X F 84	Yrs.	Months Days	Hours Min.	(Month, Day 11/17/1		irthplace (State or Foreign Country) Cyland
	and .w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
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	th the or 28a e rotii	Director	MD Somers 10e. Street and Number	et Pri	ncess	10f. Zip Code		1	l 0g. Citizen of What (Country?
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	ler de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (9 n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	
036	urs af	by	Widowed 4 Divorced	d 1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Vhite
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do they then "netural", or items 23a or 28a-f show do ther then "netural", or items 23a or 28a-f show event, the Medical Evantiner must be notified at	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa	furing most of wo	orking	16b. Kind of Busines	
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d 2	filed Hygie other		12 17. Father's Name (First, Middle, La	none none	Home	maker	18. Mother's Na	me (First, Middle,	Own Home Maiden Sumame)	2
/lan	should be ind Mental marked umatic ev	To Be	Henry E. Becker			:	Norma V	/irginia	Jory	
Maryland	0 0 0		19a. Informant's Name/Relationship						r, City or Town, State,	
	1 and Health em 27		Deborah Courtne 20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of	1		1timore, N 20c. Location - City of	
Baltimore,	Pages nent of I int: if ite		1 Burial 2 Cremation 3	B □Removal from State	cemetery, cre	matory or other place			alisbury,	
a T	permit. Departm Importe any inju		1. Signature of Funeral Service Li		2:	2. Name and Addres inman Fun	s of Facility		,	
<u> </u>	90 E # 9(AUXBO Z VIA	Me A M0029	5 1	1673 Some	rset Ave	Princ	ess Anne,	
l.		1	23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplication, that caused the dea nly one cause on each line.	th. Do not en	ter the mode of dying	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical	V	Immediate Cause (Final disease or condition resulting in death)	a		reumonia				2 days
	Examiner			Due to (or as a consec		SCVD				Edmin
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause Cause of Lighty	Due to (or as a consec						73
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	nuence of):					
8760,	sate be executed physician and the burial-transit	ai E		d	4407100 31).					
9	tificate ng phys as the	ledic		0.						
Box	tth cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		DEctopic pregnancy			23d. Date of d	
P.O. E	The law requires that the death certific are has been signed by the atlending p page 2 should be detached for use as I	Physician/Medical	1 Yes 2 No	4□Pregnant at time of o	death 5[Other (specify)			Month	Day Year
	that the poly detac		Part II. Other significent condition	s contributing to death but not re:	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sign should be	ed by						1 🗆 Y	es 2 No 3 7	Probably 4 Unknown
Vital Records,	law re as be	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
<u>س</u>	cate h							perform 1 Yes	med? death? 2 No 1 Ye	es 2 No
Ĭ,	Physicien: this certificatal director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	Othe		ath (Check only or		
o	g Phy er this ieral d	F .	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injury Work	at		ence 6 Other (Sp ow injury occurred	ecity)
Sior	endin sath. or: Aft he fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion	Injury		res 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin		iome, farm, st ify)	reet, factory, office		28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physician: To the best of my known	owledge, deat	h occurred at the tim	e, date and place	e, and due to the c	ause(s) and manner a	as stated.
	To the Ho within 24 To the Fu	Medical	one)	xaminer: On the basis of examina and manner stated.	ation and/or in	vestigation, in my op	inion, death occi	urred at the time, d	ate and place, and du	ue to the cause(s)
	or with	2	29b. Signature and title of certifier			29c. License			9d. Date signed (Mor	
			30. Name and address of person w	ho completed cause of death (the	m 23a) (Tvne		1359		July 1015	2005
			DR. USHA M	VANESAN 1415.	S. Divis	JON ST S	SALISBUR	7 70 210	104	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign.	ature	_			+	
	Registr	ar	.111 1	2 2005	. AL	Level 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Aguero Caceres 8 2005

4b. City, Town, or Location of Death

3:11 PM

4c. County of Death Baltimore

/Medical **Examiner**

Physician

1 - For State Registrar

Northwest

4a. Facility Name (If not institution, give street and number)

Hospital

Center

Funeral Director

rai, or items 23a or 28a-f ehow Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death \(\text{Department} \) of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s any injury or other traumatic event, the Wedical Exarth art muttle once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, P.O. s been signed b should be deta Division of Vital Records, To the Hospital or Attending Physician: director. his funeral After frours after death. 124 hours at

Randallstown
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 1 Month Day 1997 8 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑**M 2□F 27 none Yrs Honduras Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Reistertown Baltimore MD 1 ☐ Yes 2XNo Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 423 Valley Meadow Circle #T-3 21136 Honduras 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 X Yes 2 □ No Specify: Honduras 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aluminum Siding Installer Construction 10 18. Mother's Name (First, Middle, Maiden Surname)
Daisey Isabel Caceres 17. Father's Name (First, Middle, Last) Hector Leonardo Aquero Rodriguez 19b. Mailing Addiess செர்ந்தி இருந்து இரு இது இருந்து இரு இருந்து இரு 19a. Informant's Name/Relationship (Type, Print) Daisey Isabel Caceres/Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State Tegucigalpa, 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cemeterio Jacaleapa 7/16/05 ° 4 □Donation 5 Other (Specify) Honduras 21. Signature PHILIP ADERTMALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Multiple organ system
Due to (Ir as a consultate of): > 24 hours disease or condition resulting in death) > 72 hours response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last > Imonth Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown marasmus obstruction 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No of chronic inflammation 2 No Anemia 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8, 028462 2005 July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland 21133 Northwest

Registrar

Boston MD

Day, Year

within 2

0

Hospital

32 Registrar's Signature

Center

			1 - For State Registrar	State of M	Maryland		artmen			and M		Reg. No.	200	15	24245
I	Physici /Medio	al	1. Decedent's Name (First, Middle, to Constance Cathe	erine Com	ella		ah Cin.	T	l analina a	4 Death	July 9,	200)5		3. Time of Death 12:10 a M
	Examir Funeral		4a. Fecility Name (If not institution, g 3909 2nd Street 5. Sociel Security Number 6		Age (In yrs. Ia	ast birthday)	Nort If Under	th Be	Location of each	24 Hrs.	8. Date of Birt	Ca	County of D		ce (State or Foreign
	Director	1	103–16–9505 Usuel Residence of Decedent	1□M 2XF	82	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da 9–16–19	y, Year) 122	N	Country EW Y	ce (State or Foreign ?) Ork
	the Marylan 28a-f show offilied at	ector	MD Calvert 10e. Street and Number	-	1	rth Be	each	Carlo				100 000			f. Inside City Limits 1 Yes 2 No
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21215-0036	led within 72 h ygiene. her then "natu it, the Medica	Completed	15. Decedent's (Specify only highest (Specif	college (1-40	r 5+)	(Give life.	dent's Usua kind of wor DO NOT us nemake	k done d e retired,	uring most			Own	Home	ss/Indu	stry
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Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Age	ensee		urrect	2. Name an	d Addres	s of Facility	yLee	-2005 Funera and Blv	1 Ho	nton, M	lver	t P.A.
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	To the Within To the	Me	29b. Signature and the of certifier	mer	_				0 3 7	0			e signed (Mo		y, Year)
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			1 _ State	-	artment of He			2005	21 21 6
			Registrar 1. Decedent's Name (First, Middle, Last)		lilicale of D	ealli	Reg. I	15 003	3. Time of Death
F	Physicia		Carol Sue Couchenour				Month I	Day Year 2005	
	Medic/ Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	7:05 A. M
			Calvert Memorial Hospital		Prince F	rederic	ς	Calvert	
	uneral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign
Di	rector	-	214-80-8438 42 Usuel Residence of Decedent	Yrs.			March 25,		
land	Mo N			Oc. City, Town or Lo	ocation				10d. Inside City Limits
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Pages Pent of	t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)			1			
Baltimore, permit. Pages 1 ar Department of Hee	Importent: If is any Injury or one		21. Signature of Funeral Service Licensee	Metropol.	LCan Crema 2. Name and Address	of Facility Rai	I//UD AI	exandria, al Home	, Virginia
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Di To the Hospitel or within 24 hours afte	To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	one) and manner state 25b. Signature and title of ceptitier	d.	29c. License			Datersigned (Monti	
ř š	500	-	1 Mass		7 37	100	6	1/17/	3.
			30. Name and address of person who completed cause of dea	ith (Item 23a) (Tune	Print)	200		11/1	
10)		RAFIK NASK ND, 325 for	un Squa	40r lu	aby 1	10 206	57	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	Signature					
	Registr	ar	JUN 2 1 2005 \ A	'sever &	Cools				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician RALPH EDGAR CHRONISTER, SR. 27 June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Lorien Taneytown Taneytown Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 21, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□F 217-50-3721 55 **Director** Pennsylvania Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f ehov Tre Madical Examinar must be instilled at Maryland Carroll Taneytown 1 ☐ Yes 2 ▼ No Director 1325 Trevanion Rd. 10f. Zip Code 10g. Citizen of What Country? 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked off jury or othar traumatic avan Eldo Wesley Chronister Carrie Stem 19a, Informant's Name/Relationship (Type, Print) Rebecca Iser/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Trevanion Rd, Taneytown, MD 21787 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or once. Grace Rocky Hill Cem. July 1,2005 Woodsboro, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licenses . Skiles M00534 ohn ! 136 E. Baltimore St., Taneytown, MD 21787-2182 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician UROSERSAS the days /Medical Due to (or as a consequence of): **Examiner** meurogeni B12dder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): burial-transit The law requires that the death certificate be executed COND CERTIFICATION ASSISTANCE OF MEDICAL EXAMINER 68760 Physiclan/Medical Be under the 1 as Box IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death ģ in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) o. 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 ₹No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 XYes 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Driver of auto involved in after death. 10/06/2004 1 Yes 2 No 11:55a.m. investigation 2 Accident collision 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Clear Ridge & Pipe Creek Rds., Union Bridge, filled in by 4 - Homicide within 24 hours a To the Funaral D Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number U-29-05 D 43643 ASS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATE 1 rumas Dr. TENETTOWN, MD 7 4200 A. 31. Date filed (Month, Day, Year) 82. Registrar's Signature 1 9 2005 Registrar

		-	1 - For State Registrar	State of Maryland	/ Depai	rtment of H rificate of I	ealth and M Death	lental Hy	giene ₂ 0 (05 24248
-	Physicia	an	1. Decedent's Name (First, Middle, Last)	T	0	thel	To	2. Date of Dea	Day	Year 2/23 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give str	1, 1.	,		Location of Death	- ary	4c. County of	
	Funeral Director		5. Social Security Number 222-58-7439	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da AUG 29	h y. Year) , 1960	9. Birthplace (State or Foreign Country) Delaware
	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	e Mary Ba-f sh	ctor	Delaware New Cast	le Wi	1mingt					1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number 310 West Reamer Av	enue		10f. Zip Code 19804			10g. Citizen of W United	States
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Maderal Examinational Let notified at an once.	Funeral Director	11. Marital Status 1 X Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M.No If Yes, Give	1	/as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Race Black Specify:	e - American Indian, k, White, etc.
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Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type William F. Cathell		,		and Number or Run Ave., Wi			9804
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	,		30. Name and address of person who con	The John:	s Hop	ans Hose	of Oatic	ONWol	Fe St Bo	He MDZIZ87
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Physician Medical Examiner Sequential state of condition	76		1	3a. Part1. Enter the disease, or co	I ILIVIA I I		16/3 Sorter the mode of d	merset Ave lying, such as cardia	c or respiratory ar	ress Ann	Approximate
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To Sech In Affection IM F. Concont St. Solish Lot MO 21801	1	Fune Fune fely fil	Icai	(Check only 2 Medical Ex	aminer: On the basis of examin	nowledge, dea nation and/or ir	th occurred at the rvestigation, in m	time, date and plac y opinion, death occ	e, and due to the durred at the time, d	ause(s) and mai	nner as stated. and due to the cause(s)
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0 7	4c. County of Death
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50	be filed within 72 hours after death with the Marylan tal Hygliene. Id other than "natural", or liams 23a or 28a-1 showland the motified at avant, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 9 Year or Dates:	1 ☐ Yes 🏖 No Specify:		Specify:
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ore	ges 1 au it of Hea If itam or otha		20a Method of Disposition 20b. Place of Di	sposition (Name of Date crematory or other place)	200	c. Location - City or Town, State
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Г			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
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o D	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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					performed	l? death? No 1 ☐ Yes 2 ☐ No
VII	slciar	o Be	25. Was case referred to medical examinent? 1. ■ Yes 2 □ No	26. Place of Death (C/		a 510 y
0	는 무 등	-	27. Manner of Death 28a. Date of Injury 28b. Time	e of 28c. Injury at 28d.	. Describe how in	e 6 ☐Other (Specify) injury occurred
0	Attanding Ph or death. actor: After th by the funeral	atio	2 Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		
JIVISION	or Atta Iter de Ilracto n by th	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street City or Town, St	t and Number or Rural Route Number, tate)
ב	pital ours a aral D filled i	O	29a. Certifier 1 Cartifying Physician: To the best of my knowledge di	path assured at the time, data and place, and	due to the course	-(-)
	To the Hospital or Attanding Physician: within 24 hours after deals. To tha Funaral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) 22 Medicel Exeminer: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s)
	To the vithin comp	Ĭ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Horndon Brasta Do	15005382	-7 J	wy 1/ 2005
1	B2.		30. Name and address of person who completed cause of death (Item 23a) (Ty) SM (V - dor Sylv3 TeV) 300/ /do	spital Drive C	Lave	a margland
	Sta Registr		31. Date filed (Month, Pay Year) 2 2005 32. Resistrar's Signature	Soules	6	0/
						· ·

			1 - For State RegistrarAMEND#160+18p	State of Marylan				_	giene	5 21.251
			Decedent's Name (First, Middle, La					2. Date of De	ath	3. Time of Death
	Physici /Medic Examin	al	Hung Tang 4a. Fecility Name (If not institution, given	Dinh		4b. City, Town,	or Location of Dea	July		Year 2005 10:50P M
	Funeral Director	о. П	567-39-6577	sing Home Gex 7. Age (In yrs. QMM 2 F 64	last birthday) Yrs.	Hyatts If Under 1 Yea Months Days	r If Under 24 Hr	. (Month, Da		Georges 9. Birthplace (State or Foreign Country) Vietnam
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	ocation				10d. Inside City Limits
	28a-f	rect	Maryland Prince (Georges Gre	eenbel	10f. Zip Code			10g. Citizen of W	1 Yes 2 No
	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or items 23a or 28a-f show event. Ite Medical Examinational the motified at	Funeral Director	8551 Greenbelt Ro 11. Marital Status 1 □ Never Married 2√√√√ Married	ad #T2 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No	.S. 13.	20770) Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Vietnam	
21215-0036	turaf, o	by	3 Widowed 4 Divorced	Year or Dates:	16a. Dece	1 ☐ Yes 2 🕅 No dent's Usual Occi	upation		Specify:	Vietnamese
215	within 72 ene. than "ne	Completed	(Specify only highest gr Elementary/Secondary (0-12)		(Give	kind of work don DO NOT use retir	e during most of we	orking	Jeweler	3. To Sa Friday.
d 21	e filed withln al Hygiene. other than '		17. Father's Name (First, Middle, Las	4	Sel:	Employ		ume (First Middle	Jewler/S	Shoe Repair
Maryland	Mental in the document of the	To Be)inh			Loan Loan		ran Tran	•
lary	Pages 1 and 2 should be ment of Health and Mental ant; if item 27 is marked ury or other traumatic ever		19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	at and Number or F			State, Zip Code)
	1 and Health em 27 ther tr		Diep Hingtgen, 20a. Method of Disposition	20b. F	Place of Dispo	BOX 3208		a Beach,	FL 3293	2 City or Town, State
Baltimore,	ari ar of selection of selectio		1 SpBurial 2 ☐ Cremation 3 5	Removal from State	semetery, cre	matory or other pi lemorial	J11	ly 13,		ivo-
altii	permit. Page Department Important: fi any injury o		21. Signature of Fune al Service Lige	·· rai			ress of Facility Memoria		Home	Virginia
	20129		Jung / h	M00956	5	9902 Br	addock R	oad, Fai	rfax, Vi	rginia 22032
	Physician	i ()	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line. _aCancer of L		ter the mode of ay	ring, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 2 Months
	/Medical Examiner		resulting in death)	Due to (or as a consec						
8760,	cate be executed obysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.						
9	ertificate ing phys e as the	Medi	IF FEMALE:							
.O. Box	at the death certifice by the attending pt tached for use as to	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	□Ectopic pregnan □ Other (specify)	cy		23d. Date Mon	e of delivery th Day Year
rds, P	signed be de	by	Part II. Other significant conditions Chronic Obstruct			inderlying cause g	jiven in Part I.		_	bute to the cause of death? 3 Probably 4 Unknown
of Vital Record	as b	Completed	Osteoporosis					24a. Was	psv pi	Vere autopsy findings available
al B			Metastatic Disea	se				perfo	ormed? de 2∭No 1	eath? ☐ Yes 2 ☐ No
Vit	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	FR/Outnatie	et 30 DOA	thor	eath (Check only o	one) dence 6 □Othe	r (Spanity)
	ding h. After fune	-	27. Manner of Death 1 Natural 2 Accident Next Section 1 Natural 5 Pending investigated	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inj			how injury occurre	11 27
Division	tal or Attendi is after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not l 4 Homicide determined	00 Gloss of Injury At h	ome, farm, st fy)	reet, factory, office	Э	28f. Location (City or To		or or Rural Route Number,
	To the Hospital or within 24 hours attento To the Funeral Direction completely filled in the formulation of	edical	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exe	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the overtigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the P within 24 To the P complete	M	29b. Signature and title of certifier	. Q.f.	0		nse number			(Month, Day, Year)
	10		Kullia	4 / Ca	Qi.		9609		7.9.	O
			30. Name and address of person who Raman R. Tuli, M.			,	Rainier.	MD 207	12	
	Sta Regist		31. Date filed (Month, Day, Year)	39. Registrar's Signa	ature Son	while while		207		

State of Maryland / Department of Health and Mental Hygien 205 24252 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Joyce ANN 16:550 M 106 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ALTIMORE NIVERSITY OF MARY LAND MEDICALS 45 TEAS BAUTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 6. Sex 8. Date of Birth (Month, Day, Year) Dec. 13, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 😿 F 69 1935 Pennsylvania Director Dec. 188-26-4045 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits r then "natural", or itema 23a or 28a-f show the Modical Ezaminar mad be notified at Seaford Director MD Dorchester 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6032 Oriole Drive United States 19973 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, elc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INO Specify: White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Other then Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Nursing or other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked othe any Injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Scott Burgess Anna Mae Dobler Burgess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 19a. Informant's Name/Relationship (Type, Print) 26365 Burrsville Rd., Lot H, Denton, MD Susan A. Carey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bloomery Cemetery 07/23/05 * 4 ☐ Donation 5 ☐ Other (Specify) Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A 21. Signature of Funeral Service Licensee DOC. aris 216 N. Main St., Federalsburg, MD 21632 Coale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Kes 0119 Glir resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Coron and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 PNo 24a. Was an this certificate has autopsy performed? 1 Yes 2 □ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: ٥ 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 2 ER/Outpatient 3 DOA completely filled in by the tuneral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1) Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South break St @ DUNKE w 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State Registrar	State of Ma		artment of rtificate or		and Mental Hy	Reg. No)	21.252
	Physici /Medic		1. Decedents Name (First, Middle, I	Cast)	Evan	S		2. Date of De Month	Day Year	C3. Fine of Death Y:16 P M
	Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town,	, or Location of	f Death	4c. County of Dea	ath
			BON SECOUR	Cov. 7 Ac	a (la ura la at hinth da u	BALTIM If Under 1 Yea		24 Hrs 9 Date of Bi	th O.B.	11-1
1	Funeral Director		5. Social Security Number 2 2 9 - 6 2 - 6 7 8 7	. Sex 7. Ago 1 2 M 2 ☐ F	e (In yrs. last birthday) 61	Months Day			1944 VIF	rthplace (State or Foreign ountry) CGINIA
			Usual Residence of Decedent		10c. City, Town or Le					Land Inside On Living
death with the Maryland	show	ō	10a. State 10b. County Iaryland		BALTIMOR					10d. Inside City Limits 1 X Yes 2 □ No
the N	28e-	Directo	10e. Street and Number		BHBI THOI	10f. Zip Code	· · · · · · · · · · · · · · · · · · ·		10g. Cîtizen of What C	ountry?
with	23a or	ai Di	1840 W FAIRMON	VT AVENUE		2122.	3		U.S.A.	
9	or Ita	i by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗹 N		gin? (Specify Yes or No , Puerto Rican, etc.)	o- 14. Race - Am Black, Wh Specify: B	te, etc.
21215-0	ene. than "natu na Medical	Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work don DO NOT use reti K DRIVE	ie during most red)	of working	16b. Kind of Business	s/industry
Maryland 2	Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, La	st)				r's Name (First, Middle) RTY GRAY	, Maiden Sumame) THOMPSON	
ore, Mary	Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", of any injury or other treumatic event, the Medical Extra once.		20a. Method of Disposition	SISTER)	1 6 6 9 9	HISTO	RYLAN		er, City or Town, State, SAW VIRGI 20c. Location - City o	NIA 22572
Baltimore,	partment o portent: If y injury or ce.		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	cify)	NEW ZION	BAPTI	ST CH.	7/21/05 BERRY O.	WARSAW VA	.22572
, a &	Depa Impo any ir	-	120,0,1	vary	67	784 MAR	YBALL	ROAD LAN	CASTER VA	.22503
	nysician Medical		23a. Part1. Enter the clsease, or or shock, or heart bilure. List or Immediate Cause (F hal disease or condition resulting in death)	a Sep	the death. Do not ende.		ying, such as o	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	iclan and purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as	1 1	Lumonia	ά.			
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certifica		Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of de Month	olivery Day Year
ords, P	is been signed b	ted by P	Part II Other significant condition		ut not resulting in the u	inderlying cause o	given in Part I.		tobacco use contribute Yes 2 ⊠ No 3□F	o the cause of death?
Division of Vital Records, or Attending Physician: The law requires to	cate has be , page 2 sh		,					24a. Was auto perfo 1 🗆 Yes	ormed? death?	utopsy findings available completion of cause of s 2 No
Vita	certificate irector, paç	Be C	25. Was case referred to medical examiner?	Hospital:)thor	of Death (Check only		
ion of	death, ctor: After this certific y the funeral director,	ation: To	1 Yes 2 K No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da		of 28c. In	4 🗀 Nui	28d. Describe	idence 6 Other (Sp. how injury occurred	ecity)
Divis	irs after death rel Director: , led in by the f	Certification:	3 Suicide 6 Could no determine	t be ed 28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, offic	e	28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,
the Hospi	within 24 hours after d To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Ex	Physician: To the best taminer: On the basis of and manner sta	f examination and/or in	vestigation, in my	y opinion, deat	d place, and due to the the courred at the time,	date and place, and du	e to the cause(s)
To	with To com	2	29b. Signature and title of certifier	> reducal H	ouse office	r 1)	HSTY 8		29d. Date signed (Mor	th, Day, Year)
	1		KICAPAO DSOPNIO	2000 W15T	Baltimore 9	STrut	Bulti	more, Mary.	land 2122	3
	Sta Registr	- 6	JUL 2 5 200		ar's Signature	م		1		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Orren Daniel July Forsythe 9:09 12 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) May 21, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**⊠** M 2□ F 218-38-1177 65 Months Director 1940 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner: ust be notified at MD Washington Williamsport Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9406 Downsville Pike 21795 U.S.A or Itams 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1958 – 1 XYes 2 No 1964 Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 XDivorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Truck Mfg ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Machine operator 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Walter Forsythe Lottie Vera Dayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Tedrick 11423 Ernstville Rd. Big Pool, MD 21711 daughter othert 20b. Place of Disposition (Name of cemetery, crematory or other place) July 15, Smithsburg Crematory 2005 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signiture of Funeral Service Lin Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Records, P.O. the 9☐ Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 19.2 autopsy performed? res 2 No page certificate Division of Vital 1 Yes Hospitel or Attending Phyelclan: Be (25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 | ZNatural 2 | Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel D pelli 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tife of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11-12+ 31. Date filed (Month) 32. Reistrar's Signature State Registrar

			For State Registrar	State of Marylan		artment of H			giene Reg. N2 0	0.5	21,255
	Physicia	an	1. Decedent's Name (First, Middle, Last) Genevieve Ma	rah Fiahar				2. Date of Dea	ath	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s			4b. City, Town, or	I ocation of Deal		4c. County	of Death	2:40 pm ^M
	Examin	er		(166) and Humber)				41		ltimo	re
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Luther If Under 1 Year	If Under 24 Hrs				place (State or Foreign
	Director		577.22.3053	^{M 2} X 89	Yrs.	Months Days	Hours Min.	Feb. 27	1916		ington DC
	p ,		Usual Residence of Decedent 10a, State 10b, County	100 Cit	y, Town or Lo	antine.					0d. Inside City Limits
	ehov	5	,	100. Cit						'	1 Yes 2 No
	28e-1	ectc	MD 10e. Street and Number		Luth	erville 10f. Zip Code			10g. Citizen of	What Cour	
	with	ä	300 West Seminar	v Avenue		21093			U.S.A.		, .
	Jeath ms 23	Funeral Director		2. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (5	Specify Yes or No		e - Americ	
စ	or itan	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo	1	lfYes, specifyCuba 1□Yes 2[X[No	n, Mexican, Puer Specify:	to Rican, etc.)		ck, White,	etc. White
93	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23e or 28e-f ehow ent, the Madical Exemitmer, dat be natified at	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 165 2LANO	эрөспу.		Specif	y: 	MILLE
2	natu	ete	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wa	nrking	16b. Kind of B	usiness/In	dustry
12	within sne.	du	Elementary/Secondary (0-12)	College (1-4or 5+) -4		emaker	"		Over	1 Home	9
d 2	Hygie Hygie other	Be Completed	17. Father's Name (First, Middle, Last)	<u> </u>	HOM	emaker	18. Mother's Na	me (First, Middle,	-117		<u>-</u>
an	id be ental kad c	To B	Charles Mer	cer Marsh			Ge	enevieve	Wilder	Cut1	er
Maryland 21215-0036	s may		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	er, City or Town	State, Zip	Code)
Σ	and 2 salth a n 27 I er tre		Martin Fisher/ Sor			lipping T	ree Lane				21030
altimore,	Os is is		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, crei	nsition (Name of matory or other place	(e)	Date	20c. Location		
Ē	Pag tment tant:		`4 □ Donation 5 □ Other (Specify)	FI		fort Crem	Ju	ly 12,05	Alexand		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28e-1 ehow eny injury or other traumatic event. The Modical Examiliant is useful intiffied at once.		21. Signatur of Fine all Service License	oseph Gaw enue NW		ons,	Inc.				
ı			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
B	Physician		tmmediate Cause (Final disease or condition resulting in death)	Dilated Card	liomyop	athy				1	2 months
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
		- La	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	quanea of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	quence of):						
8760,	cate be executed physician and the burial-transit	Physician/Medical	d								
9	entific ling pl	Med	IF FEMALE:								
Box	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	al death 3	Ectopic pregnancy Other (specify)	,		1	te of delive onth	ery Day Year
Р. О.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9☐ Unknown	ieatii 5L	Other (specify)					
	that the the the the the the the the the th	y Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
rds	n signe	d by	Hypothyroidism					1 🗆 1	es 2 No	3 🗌 Prob	pably 4 Unknown
CO	aw requires s been sign	olete						24a. Was		Were auto	psy findings available
R	The la	Completed						autop perfo 1 Yes	rmad?	prior to co. death? 1 ☐ Yes	mpletion of cause of 2□ No
ta		BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o			
<u>_</u>	Physic this ce al dire	일	1 ☐ Yes 2 ₹ No	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4. ⚠ Nursing I	Home 5 Resid	tence 6 □Oth	ner (Specif	y)
n c	Attending Physiclen: r death. ector: After this certifici by the funeral director,	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	now injury occur	red	
isio	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome form st		Yes 2 □No	28f Location //	Street and Numl	er or Bura	il Route Number,
Division of Vital Records,	l or Attendented of the death Director:	Certification:	4 Homicide determined	building, etc. (Special	fy)	eet, factory, office		City or Tox	vn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospitel or Attending Phwithin 24 hours effer death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Check only 21 Medical Examin	ician: To the best of my knoner: On the basis of examina	owledge, deat	h occurred at the tin	ne, date and plac	e, and due to the	cause(s) and m	anner as s	tated.
	To the H within 24 To the F complete	Medical	one)	and manner stated.							
	To Too	~	29b. Signature and title of certifier	0		29c. Licens D4212			July 5		
	15		20 Normand	moleted estimated for the first	m 03c) / =				July J	, 200	
	I		30. Name and address of person who co William D. McConne			,	5 Ro1+4∞	ore MD	21212		
	Sta	te	31. Date filed (Month, Day, Year)	39. Registrar's Signa	ature	. ES DL. 11.	, nartill	ore, ru	<u> </u>		
	Registr		JUL 12 200	39. Registrar's Signa	6,00	ALL!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 4a. Facility Name (If not institution, give street and number) iO. 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantie General itospital Berlin Workester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months 219-62-0651 Director 25, 196 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Nes 2 □ No Director Maryland Ocean Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 125 Newport Bay Drive, Apt B United States of Ameri 21842 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other than College (1-4or 5+) -unbina lumber 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be f and Mental h Fields Stanley Catherine itermans dor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type permit. Pages 1 and 2 Department of Health a Important: If item 27 la any injury or other trau Sandra Frelds wife Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Salisbury Grematay July 12, 2005 Salisbury, Maryland 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lambridge MD Approximate Interval Between Onset and Death Hepatic Encephalopathy Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Endstage Hepatic Circhosis Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): 68760 Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Phermonia 2 No 3 Probably 4 Unknown Completed GI Bleeding 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Sepsis 1 Yes 2 No or Attending Physician: 25. Was case referred to med 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

28a. Date of Injury
28b. Time of Injury
28c. Injury at Work?
3 Suicide
3 Suicide
4 Homicide
28a. Date of Injury
28b. Time of Injury
3 Suicide
4 Homicide
28b. Time of Injury
4 Work?
4 Homicide
28b. Time of Injury
4 Work?
5 Pending
5 Injury
5 Work?
6 Could not be determined
28b. Place of Injury
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6 Injury
7 At home, farm. street, factory, office
28b. Location (Street and Number or Run
2bl. Location (Street and Number or

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19 **Physician** JULY 12:48aM MADELON FAVINGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Kent Chester River Hospital Center Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec 24 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 916 1 ☐ M 2 🛛 F Delaware 88 176-20-1881 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show the Mudical Exacultuational be notified at 1X Yes 2 □ No MD Chestertown Director Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 229 North Kent St. 23a 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ⊠No If Yes, Give Year or Dates: 14. Race - American Indian. filed within 72 hours after deal Hygiene. other than "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 Is marked other th any injury or other traumatic event, ITE, ODGE. Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Winsor Harlon White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24102 Cliff Dr. Ext. Worton, MD. 21678 John H. Favinger (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/19/05 Kent Cremation Smyrna, DE. 1 4 □ Donation 5 □ Other (Specify) M00510 Galena Funeral Home of Stephen L. 21. Signature of Pope roll Service Licens Schaech 118 West Cross St. Galena, MD. 21635 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Figal Physician YEARS OVERIAN CANCER METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CORONARY ARTHAROSLUE ROSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Complet PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? HYPBRCHOLESTEROL 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) J_o 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural
2 Accident within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan IS 00057509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

James E. Lacey, M.D.

31. Date filed (Month, Day, Year)

JUL 2 5 2005

32. Registrar's Signature

516 Washington Ave. Chestertown, MD. 21620

Robert C. Forbeck 05-4876 AKG

1
Physician /Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend/Universe of Health and Mental Hygiene

		4	Amend/ 1 = State Registrar	Jinnend i tem#1 State of Maryla			PREAITR'S of Death			iene	2005	21.250
4		菱	Decedent's Name (First, Middle, Last	st)	***************************************				2. Date of Dea	th	Your	3. Time of Death
	Physicia /Medic		Robert	Chester	For	beck, Jr			July	19,	2005	12:22 A M
Jan 1	Examin		4a. Facility Name (If not institution, give			1	m, or Location	of Death			County of Death	1
1		40	Memorial Hospita		rs. last birthday)	Cumber 1 Y		24 Hrs	9 Date of Birth		legany	Iplace (State or Foreign
	Funeral Director	7	5. Social Security Number 6. S 220-74-4113	M 2□F	Yrs.		ays Hours	Min.	8. Date of Birth (Month, Day 07/01/196		Maryl	intry)
	- 1		Usual Residence of Decedent	41					0//01/170) +	TRITYI	
	yiang	. [10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits 1 X Yes 2 No
	Sa-f s	cto	MD Allega	ny	Cumber							
	or 24	Director	10e. Street and Number			10f. Zip Co				l0g. Citiz	en of What Cou	untry?
-	8 23a		406 Chestnut Str	eet 12. Was Decedent Ever in	NI C 12 1	Was Decedent	21502	inin? (Spe	ofy Yes or No.	1	USA 4. Race - Amer	ican Indian.
0	filed within 72 hours after death with the Maryland Hygiene, Hydiene, or Items 23s or 28s-f show ant, the Madical Examitive count to notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify			cify Yes or No- Rican, etc.)		Black, White	, etc.
2	rel', o	l by	3 Widowed 4 Divorced	If Yes, Give 12 Year or Dates:		1 1 1 1 1 1 2 2 2 2 2 2	140 Specily.				Specify: Whit	
213-0030	72 h	etec	15. Decedent's Ed (Specify only highest gra	fucation de completed)	(Give	dent's Usual O kind of work d DO NOT use ri	one during mos	st of workin	ng	16b. Kin	id of Business/h	ndustry
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1116.	Technic					Auto Bod	V
ט ס	be filed withir hal Hygiene. ed other then event, the M	0	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle,	Maiden :		
Maryland	permit. Pages 1 and 2 should be! Department of Health and Mental I Important: If Item 27 is marked of eny injury or other traumatic eve once.	To B	Robert	Chester	Forbecl	k, Sr.	Na	ncy	Le	e	Logs	sdon
a	and Is ma	o Y	19a. Informant's Name/Relationship (Town, State, Zi	ip Code)
2 .	and fealth m 27 her tr		Nancy L. Forbeck / mo		b. Place of Dispo				rland, Ma	3	d 21502 cation - City or 1	Fown State
0	iges 1		20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 ☐	Removal from State	cemetery, crei	matory or other	place)					
baltimore,	it. Pa intmer intant njury		4 □ Donation 5 □ Other (Specifical Service Licer		Cumberland		3	07/20/			berland, eral Home	
n n	Department of the partment of		Xalux (?	(ille					Cumberla	,		21502
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	Physician		Immediate Cause (Final disease or condition	a Cardiac A	rrythmia	,						Onset and Death
$I_{\sigma_{-20}}$	/Medical		resulting in death)	Due to (or as a con-		•						
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	execu n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a con:	sequence of):							
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9	intifica ing ph	Med	IF FEMALE:							1		
X Q Q	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregr				2	3d. Date of deliments. Month	very Day Year
o	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown	or death 5	Other (special	y/					
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rds	w require: been sig should bo								1 🗆 Y	es 2[□No 3□Pro	obably 4 Unknown
Hecords,	e lawre has bee je 2 sho	Completed							24a. Was autop		24b. Were au	topsy findings available completion of cause of
Ĭ		Com							1 Yes	med? 2 No	death? 1 (X Yes	2 No
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0	Physi this of	To	1XXes 2 No 27. Manner of Death	1 ☐ Inpatient :	2 🕅 ER/Outpatie 28b. Time o		1		ne 5 Resid		Other (Spec	cify)
0	Attending Physician: r death. sctor: After this certific by the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Yea	r) Injury	м	Injury at Work?				,	
	I or Attending after death. Director: After I in by the funer	Certification:	3 Suicide 6 Could not be determined			treet, factory, o	ffice	- 4	28f. Location (S City or Ton			iral Route Number,
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		nysician: To the best of my miner: On the basis of exan and manner stated.								
	within 2 To the I	Me	29b. Signature and title of certifier			29c. L	icense number				e signed (Monti	
			Yand Y	uthull aix			O.C.M.E	•		Ju]	ly 19, 2	2005
			30. Name and address of person who		(Item 23a) (Type	. Print)						
-			Pamela E- Sou	22 Benistrar's S	ionature		lll Pen	n Str	eet, Ba	1tin	nore, Ma	aryland 2120
	Sta Regist	ate rar	JUL 2 5 2005	Bloom B	Speciel	,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** RHEA OLEVIA GROVE 9 2005 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney Keedy Nursing Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Marke Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 220-10-3206 Director 100 Feb. 6, Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Items 23a or 28a-f abov other traumatic avant, It a Medical Examinar mast be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17427 Lexington Avenue 21740 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Completed by Specify. 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 cook Board of Education permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygimportant: If Item 27 is marked other
any injury or other traumer:
once. filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Poole Sarah C. Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ott daughter 1713 Mt. Aetna Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 7-12-05 Hagerstown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses Tred L. V. esta 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ons Myonic /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Or Completed by Physician/Medical Examiner as a consequence of) the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2500 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy this certificate 1 Yes 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2-□No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? : After 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 1 Accident 24 hours after deat Funeral Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital TG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 12323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CT HAGERSTOWN MOZITYO MI OVAL HACID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

State Registrar Raman Tuli, M.D.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

10810 Darnestown Rd., Ste. 202, Gaithersburg, MD

20878

			1 - For State Registrar	State of Marylar	nd / Depa		Health and		-	24261
	Physici	an	Decedent's Name (First, Middle, Last Erma Mar		obo			2. Date of Dea	Day Year	3. Time of Death
5	/Medic	ai	4a. Eacility Name (If not institution, give		.00	4b. City, Town	or Location of De	ath	09 2005 4c. County of De	
	Examin	er	Peninsula Regioni	21 Medical Ci	enter	ئے	Salisburg	4	War	
Ī	Funeral Director		5. Social Security Number 6. S	ex	last birthday) Yrs.	If Under 1 Yea Months Day			y, Year) 957 Per	rthplace (State or Foreign country) nnsylvania
	yland Now		10a. State 10b. County	10c. Ci	ity, Town or L	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Wicomi	co S	Salisbu	ıry				1⊠Yes 2□No
	uth with the 23a or 26 ust be no	Funeral Director	10e. Street and Number 200 Civic Ave.			10f. Zip Code 2180			10g. Citizen of What C	country?
030	d within 72 hours after death with the Maryland plane. Jane. Than "natural", or Items 23a or 28a-f show Itte Mudical Examities must be positived at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Co 1 ☐ Yes 2 N		(Specify Yes or No erto Rican, etc.)		
9500-612	n 72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation (de completed)	16a. Dece (Give	dent's Usual Occ	upation ne during most of v red)	vorking	16b. Kind of Busines	s/Industry
	I within 72 iene. I than "nai	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		bled	(80)		n/a	
Maryland	d be file antal Hyg ced othe c event,	To Be C	17. Father's Name (First, Middle, Last) James J. Gillena		7 2250	2200		lame (First, Middle, Jane Hall	Maiden Sumame)	
	and 2 should alth and Men 27 is marke ar treumatic		19a. Informant's Name/Relationship (Ronald J. Gillen						er, City or Town, State, MD 21804	Zip Code)
Baltimore,	Pages t and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition 1	Imemoval isom State		osition (Name of matory or other p		Date /13/05	20c. Location - City of Drums, PA	
Balt	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Liver			2. Name and Add HOLLOW	dress of Facility Ay Funera	ıl Home Pı		Association
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea one cause on each line.		ter the mode of d	ying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		infect	ion			10 days
	uted d ansit	Examiner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic	Renal	insuffic	i'ency			Years
,097	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consect		Heart	failu	re.		Years.
O. Box 68	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	⊒Ectopic pregnar □ Other <i>(specify)</i>			23d. Date of d Month	elivery Day Year
ds, P	as the	by	Part II. Other significant conditions of Spina Siki	contributing to death but not re	sulting in the t	underlying cause	given in Part I.		obacco use contribute	to the cause of death?
ecords,	aw raquire s been sig 2 should b	Completed	Right Hi	p Abscess				24a. Was		autopsy findings available
Œ		om	Osteogone	sis imper	fecto	λ			ormed? prior to death?	
Vital	ysician: The is certificate his director, page	Be	25. Was case referred to ical examiner?					Death (Check only o	one)	
o		. To	1 Yes 2 No 27. Manner of Death		ER/Outpatie	ME 3LI DOA			dence 6 Other (Sp.	ecify)
on	Attending Physician: or death. ector: After this certification by the funeral director.	ation	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury	W	ork? □ Yes 2 □ No		,.,	
Division of		Certification;	3 Suicide 6 Could not be determined		home, farm, si	treet, factory, offic	ee ·	28f. Location (: City or To	Street and Number or I wn, State)	Rural Route Number,
	To the Hospitel or Attenwihin 24 hours after deating the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, dea nation and/or i	th occurred at the	time, date and play y opinion, death of	ace, and due to the ccurred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	To the Comp	Ň	29b. Signature and title of certifier	Delu'			o60715		29d. Date signed (Mo	nth, Day, Year)
•	3		30 November 1	completed course of death (in	om 22a) /T				Jony 16	0 4002
	3		30. Name and address of person who S.A. Reza Jalahi			F" Salis	buy, mi	10816 0		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature K	hack :				

		•	1 - State Amend Item 23,25 per ME, G845 Cert	tment of Health and Mental H 119/05dh ificate of Death	ygiene Reg. N2 0 0 5 2 4 2 6 2
			Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
	Physicia /Medic		Rose Marie	Gentile Juni	21, 2005 6:10 AM
,	Examin			4b. City, Town, or Location of Death	4c. County of Death
	sis.		The Johns Hopkins Hospital	If Under 1 Year If Under 24 Hrs. 8. Date of B	Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Vsual Residence of Decedent		Day, Year) Country)
	land		10a. State 10b. County 10c. City, Town or Local	ation	10d. Inside City Limits
	Marylan II.ed at	tor	PA YORK YORK		1 ☐ Yes 2 🛣 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th wit		7 Jamison Drive	17402	USA
980	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or tleme 23a or 28a-f show event, the Mcdical Examiner must be notified at	by Funerai	1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 7 No Specify:	14. Race - American Indian, 8lack, White, etc. Specify: White
2-0	n 72 hours "natural",	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	nt's Usual Occupation ind of work done during most of working	16b. Kind of Business/Industry
21	ithin 7 ne.	npie	Flementany/Secondary (0.12) College (1.40r.5+)	O NOT use retired)	Home
2	be filed withir tal Hygiene. Id other than event, the M		17. Father's Name (First, Middle, Last)	emaker	
Maryland 21215-0036		To Be	Joseph Cirillo	18. Mother's Name (First, Middle Cutomea	
Mar	s 1 and 2 should I Heelth and Men Item 27 Is marke other traumatic			Address (Street and Number or Rural Route Num May wood Roll You	nber, City or Town, State, Zip Code)
ē,	es 1 and 3 of Health f item 27 r other tr	Ì	20a Method of Disposition 20b. Place of Disposit	tion (Name of Date	20c Location - City or Town State
altimore,	Page ment o tant: If jury or		1 ★ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	atory or other place) Lemetery Tune 15,	York, PA
Ball	perrit. Pages 1 and 2 Department of Heelth a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	Name and Address of Facility Effective ralling T	me YOHL, PA 17403
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter shock, or heart failure. List only one cause of each line.		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Severe mitroresulting in death)	al regurgitation	3 years
	Examiner		Due to (or as a consequence of):	3 1 1	2
		Jer	Sequentially list conditions, b. Tany leading to immediate Due to for a a consequence of):		10
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	/ / / X	EXAMINER
ő,	ate be executed thysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	CERTIFICATION APPROVED BY MEDI	CAL
8760,	ate ohy:	dical	d	TOTAL ON APPROVE	
9	nding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	OBRILL	
Box	Bath atte for	Physician/Me	in the past 12 months?	Cotopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
P.O.	t the d by the tached	hysi	1 Yes 2 No 9 Unknown 9 Unknown		
	es that igned t be det	by P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?
) ju	v require been sig should b	ed	ttyper tension	1	□Yes 2 No 3 □ Probably 4 □Unknown
ital Records,	e law re has be ge 2 sho	Completed	Coronary Arteny Disease	24a. We	topsy prior to completion of cause of
E C	The I	Соп	Atrial Fibrillation	pe 1 □ Yes	
Zita Zi	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	y one)
30	Physical direction	7	1 □ Yes 2 No Hospital: 1 N Inpatient 2 □ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		e how injury occurred
35	ding I h. After funer	tion	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	e now injury occurred
Divisi	Attending Physician: It death. ector: After this certifics by the funeral director.	ifica	3 Suicide 6 Could not be		(Street and Number or Rural Route Number,
ā	s after sal Dire	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)	City or I	Town, State)
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death of the best of my knowledge, de	occurred at the time, date and place, and due to the stigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			July Small MD	RES-000	June 21, 2005
	10		30. Name applied address of person who completed cause of death (Item 23a) (Type, P	et, Baltimore, Man	uland 21287
	Ch	te	31. Date filed (Month, Day, Year) JUL 1 9 2005 32. Registrar's Signature	1	
	Sta Registr				

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			_ For									lental Hyg		-egibie	•
5			1 - State Registrar				Ce	rtificate	e of L	Death			Reg. No.	200	21,202
	Physici	an	Decedent's Nam		,							2. Date of Dea Month	Day	Yea	
	/Medio	al			Golden	ber)		4b. City.	Town, or	Location of	of Death	July	1 H	County of De	<u> </u>
	Exami	le!			nty Hospi					rstow				ashin	
	Funeral		5. Social Security N	lumber		7. Age (In yrs.					24 Hrs. Min.	8. Date of Birtl (Month, Day	h v. Year)	9. E	Birthplace (State or Foreign Country)
	Director		215-36-60 Usual Residence o		X		72 Yrs.					October .	31,19	32	WV
	nyland how		10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation	-						10d. Inside City Limits
	8a-f s	Director	MD	Washin	gton	Hai	ncock								1 X Yes 2 □ No
	ours after death with the Marylan rel', or Items 23e or 28a-f show Examinat must be notified at	Dire	10e. Street and Nu	_{mber} :a Villa	100			10f. Zip	^{c₀de} 1750				-	en of What	Country?
	ms 23	Funeral	11. Marital Status	a viila	12. Was Dece	dent Ever in U	.S. 13.				gin? (Sp	ecify Yes or No- Rican, etc.)	USA 1		merican Indian,
98	or Ite	y Fui		ried 2□ Marrie	Armed For 1 Tes If Yes, Give	2 No		if Yes, spec 1 ☐ Yes :		n, Mexicar Specify:		Hican, etc.)		Black, W.	hite, etc.
Ö	"neturel", dical Exa	ed by	3X Widowed	4 ☐ Divorced	Year or Da	tes:		dent's Usua						W	hite
21215-0036	.5 - 3	Completed	(Spec	cify only highest	grade completed) College (1-	40r 5 L)	(Give	kind of wor DO NOT us	rk done d se retired	<i>during</i> mos <i>d)</i>	t of work	ing	160. Kin	id of Busine:	ss/industry
21	DO	Com	5_			401 37)	Hom	emake:	r					Home	
Maryland	be od o	Be	17. Father's Name	(First, Middle, L	· ·							e (First, Middle,	Maiden S	Sumame)	
<u>Z</u>	d 2 should the and Men 7 Is marke treumatic	ဥ	19a. Informant's N				19b. Mailii	na Address	(Street :			ller al Route Numbe	r City or	Town State	Zin Code)
	12 12 12 12 12 12 12 12 12 12 12 12 12 1		Pamela Mo				10					k,MD 21		rown, Diate	a, zip oddej
Baltimore,	ges 1 and tof Heali		20a. Method of Dis	position	3 □Removal from S	20b. F	Place of Dispo	osition (Nan	ne of ther plac	(e)		Date		cation - City	or Town, State
Ë	Z Hen		* 4 Donation	5 Other (Sp	ecify)		nolowa)/05	Need	more,	PA
Bai	permit. P Departm Importer any injur		21. Sonature of Fu	uneral Service L	iconsoo	()		2. Name an				141 Wes			
			23a. Part1. Enter t	the disease, or d	complications that ca	used the deat								k,MD	21750-0368 Approximate
B	Physician		shock, or hea Immediate Cause disease or condition	(Final	only one cause a ea	ich line.	1.	E	10	len = et		•			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	J.	a Due to (a conseq	uence of)		(C	1					7-0
	Examiner	10	Sequentially list co	onditions,	b. Due to k	Menzes	14.00								141
$\overline{}$	uted f insit	Examiner	cause. Enter Under Cause (Disease or that initiated event	erlying r injury	Clay	AALV V	Cens D	Fai	lus	۵					71/
0,	an and		resulting in death)	Last	`	or as a conseq	uence of):	1	-						37
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lcal		,	d	igest	ne H	CONT	- Kar	alli	ine				SX
9	death certifica attending ph d for use as t	/Med	IF FEMALE:		23c. If yes, outo	ome of pregna	ancv							04 0-4-4	4-11
. Box	death e atter d for u	Physiclan/M	in the past 12	months?	1 ☐ Live bi 4 ☐ Pregna	rth 2 ☐ Feta int at time of d	Ideath 3	Ectopic pro					2	3d. Date of o	Day Year
P.0	at the de by the a	hys	9 🗌 Unknowr	1	9∐ Unkno										
	ires tha signed I	by	Part II. Other signi	ficant condition	ns contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I	,				to the cause of death?
Records,	w requir been si should	etec				-							es 2		Probably 4 SUnknown
Re	The lavate has	ompleted										24a. Was a autop	med?	prior t death	
Vital		e C	25. Was case refe	rred to medical						26. Place	of Deat	1 ☐ Yes		1 🗆 Y	es 2□No
of V	Physicien: this certific ral director,	To B	examiner?		and the second	patient 2			A Othe	er: 4 🗆 Nu	irsing Ho	me 5 Resid	ence 6	□Other (Sp	oecify)
o uc		lon:	27. Manner of Dea 1 Autural	5 Pending		f Injury n, Day Year)	28b. Time of Injury		8c. Injury Work	< ?	No	28d. Describe h	ow injury	occurred	
Division	deat ctor: y the	ertification	2 Accident	investig: 6 □ Could n determi	ot be 28e. Place	of Injury - At ho	ome, farm, str	M reet, factory		Yes 2□	NO	28f. Location (S	treet and	Number or	Rural Route Number,
Ö	i Sir de	Certi	4 Homicide	90(011111	buildin	g, etc. (Specif	(y)	,				City or Tow			
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	dical	29a. Certifier (Check only one)	2 Medical E	Physician: To the xaminer: On the ba and mann	sis of examina	ition and/or in	vestigation,	in my or	pinion, dea	th occur	ed at the time, o	date and p	place, and d	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier				29c	. License	e number		2	29d. Date	signed (Mo	nth, Day, Year)
)			•	200	= =				052	232	3		7/1	571-	_
	2		30. Name and add	ress of person v	mo completed caust	or of death (Item	pα (Туре.	Print)	+	Hag	er	stown	m	laryl	and
1	Sta Registr	ite ar	31. Date filed (Mor	oth, Day, Year)	who completed causs	gistrar's Sign	Apa-	de la							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	iryianu i		tificate of			Reg. No.		
	Dhuaiai		1. Decedent's Name (First, Middle, Last						2. Date of Dea	ith 211	0.5	37 inte of Peath 1
	Physici /Medio		ETTA BELL	HOLLOWA	Υ				JULY	06, 200		5:55 AM?
7	Examin	er	4a. Facility Name (If not institution, give Woodside Medic		er			or Location of Death	n	4c. County		V
Ī	Funeral		Social Security Number 6. Se	x 7. Age	(In yrs. last		If Under 1 Yea Months Day	r If Under 24 Hrs.	8. Date of Birth (Month, Day 03/25/			place (State or Foreign
	Director		249-84-6683	□M 2□F	61	Yrs.			03/25/	1944	s. c	arolina
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
	e Mar	ctor	MD P.G.		Cap	pital	Heights	3				1 Yes 2 No
	with th	Director	10e. Street and Number 4115 Shell Street	-			10f. Zip Code 2074			10g. Citizen of V	Vhat Cour	itry?
	death with the Maryland ma 23a or 28a-f show	Funerai	11. Marital Status	12. Was Decedent B	ever in U.S.	13. V		Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No-		e - Americ	can Indian,
036	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or Itema 23a or 28a-f show matte event. Its Medical Ezarre or mant be mailled.	þ	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1	Yes, specify Cu □ Yes 21/2 N		to Rican, etc.)		k, White, Bla	
0	72 ho 'netur	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)	1	6a. Deced	ent's Usual Occ kind of work don	upation e during most of wor ed)	rking	16b. Kind of Bu	siness/Inc	dustry
וצו	filed within 72 Hygiene. other than "naf ent. I'm Medici	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)		ild_Car		1	Co	elf	
22	other work	Be Co	17. Father's Name (First, Middle, Last)			U1	IIU_Car		me (First, Middle,			
ylar	should be and Mental marked o	ToE	Thomas Williams		_			Isabe	ell Mosle	∋y		
Maryland 21215-0036	12 sho h and 7 ls m traum		19a. Informant's Name/Relationship (T					et and Number or Ru r Place; (
	s 1 and 2 should Health and Mer tem 27 Is marke other traumatic		20a. Method of Disposition	or - Haspa	20b Place	e of Dispos	sition (Name of natory or other p		Date Date	20c. Location -		
Ë	Pages nent of int: If it		1 → Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,				d Cemete	ery 07/1	3/05	Washing	rton,	D.C.
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any njury or other ance.		21. Signature of Funeral Survice Licens	Freene	21	1		ress of Facility Fr				20743
B			23a. Part1. Enter the disease, or comp shock, or eart failure. List only of	litations that caused	the death. I	Do not ente	er the mode of d	ving, such as cardia	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		omy		715					3 months
	/Medical Examiner		Tooling in down,	Due to (or as			elete					> 5 years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncorpuing Cause (Disease or injury	Due to (or as a	a consequen	ice of):						>5 years
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):									12 den
68760,	ificate be executed g physician and as the burial-transit			Dua to (or as a	a consequen	ice oi).						
687	ilitcate g phys as the	ledicai		a.								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetel de	ath 3	Ectopic pregnan Other (specify)	су		23d. Dal Mo	e of delive	ery Day Year
	uires that t signed by Id be detai	y Ph	Part II. Other significant conditions co		ut not resultir	ng in the ur	nderlying cause (given in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
ord.	w require been sig should b		Hyperter	1510 m					1 🗆 Y	'es 2□No	3 🗆 Prob	pably 4 DUnknown
Vital Records,	The law nate has be page 2 sh	Completed	[1]			· · · · · · · · · · · · · · · · · · ·			24a. Was autop perfor 1 Yes	rmed2	Were auto prior to con death? Yes	psy findings available mpletion of cause of 2 No
/ita	i cian : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					ath (Check only o		-	-
Division of \	ng Physi fter this o	on: To	1 ☐ Yes 2 Ø No 27. Manner of Death 1 Ø Natural 5 ☐ Pending	1 ☐ Inpatie 28a. Date of Injur (Month, Day		Outpatien b. Time of Injury	28c. In	ury at ork?	lome 5 Resid	lence 6 0th now injury occurr		v)
<u>sio</u>	ttendi death. Stor: A / the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ırv - At home	a farm stre		Yes 2 No	28f Location (S	Street and Numb	er or Rura	al Route Number,
<u>≥</u>	al or A after I Direction by	ertif	4 Homicide determined	building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,	out, ractory, onto		City or Tow		0, 1,0,0	7 110010 11011001
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phy (Chack only one) 2 Medical Exam	/sician: To the best of iner: On the basis of and manner sta	examination	idge, death and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and ma date and place,	nner as st and due to	lated. the cause(s)
		Me	29b. Signature and title of certifier	Q	1			nse number		29d. Date signer		
•	12 B1		Vetro .	Sue				52843		7-7	- 20	∞ 5
	(2)		30. Name and address of person who o	completed cause of de		BOD (Print)	Wille !	2d S.1	e Burr	R	oune MD 201
	Sta		31. Date filed (Month, Day, Year)		ar's Sin fatur		- (0 .	-4-4-4		- (- (-, 4	,
	Regist	rar	JUL IN COOL	were to								

Registrar

				01 1 (11 -1 -1 / 0)		I IAI A	4 4 - 1 1 1 - 4 1		
			For	State of Maryland / De					01000
			1 - State Registrar	(Certificate of I	Death		g. No 2005	24265
	张 成	19 g	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia	P-1	OLGA ANGELA HAY	DEN			July	9 2005	11:50 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or	r Location of Death		4c. County of Deat	th
	LAGITIII	C1	Heritage Harbor H	on1th & Robah	Annapoli	ic		Anne Aru	nde1
10	Funkasi		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O Rid	thplace (State or Foreign
	Funeral Director			M 2∏ F 93 Yr	Months Davs	Hours Min.	Jan. 5,	1912 Mac	con, Georgia
	* C		Usual Residence of Decedent	7.5			00		, , , , , , , , , , , , , , , , , , , ,
	land ow		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Mary f sh	ō	MD Prince Ge	orge's Bowie					1 TYes 2 □ No
	the 28a-	Director	10e. Street and Number	orge s bowre	10f. Zip Code		10	g. Citizen of What Co	ountry?
	with E or					-		U.S.A.	
	I within 72 hours after death with the Maryland jiene. Jiene "natural", or Items 23s or 28s-f show the Medical Executor in the restilied at	Funeral	2604 Kennison Lan		20715		ecify Ves or No-	14. Race - Ame	erican Indian
	er de Item	'n	T. Wallet States		 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
5	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 ☐ Yes 21 No	Specify:		Specify:	440
12-0036	within 72 hours after ene. than "natural", or Ita	p	15. Decedent's Educ		acadont's Heuri Ossun	ation	1	6b. Kind of Business	lite
ប	"nad	lete	(Specify only highest grade	completed)	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	during most of work	ing	OD. KING OF DUSINESS	moustry
Z	withlir ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ookkeeping	-/		Constructi	on Ind.
N	filed v Hygie other t		10	T.	OOKKeeping	19 Mother's Nam	e (First, Middle, M		- Ind.
and	d tail	Be	17. Father's Name (First, Middle, Last)			_	` .	aluen Sumame)	
<u> </u>	should be and Mental marked umatic av	၉	Louis Cassine				Orlando		
Mary	s 1 and 2 should I Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty)		Mailing Address (Street				_
_	and and n 27 n 27 ner tr		Sandra Ryan, Daug		4 Kennison				
Baitimore,	oth		20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place	ce)	Date 2	0c. Location - City or	Town, State
Ē	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		incoln Ceme		/2005	Brentwood,	Maryland
	. 5 5 5		21. Signature of Funeral Service Lipense					eral Home,	
n	permit Depar Impor any in		A Con	0				ttsville,	
	1. 4.		23a. Part1. Enter the disease, or compli- thock, or heart failure. List only or	carions that caused the death. Do no	t enter the mode of dvin	ng, such as cardiac	or respiratory arre	st.	Approximate
				e cause on each line.	1/0	1-6	6		Interval Between Onset and Death
	Pnysician		Immediate Cause (Final dis + se or condition resulting in death)	confest	u per	- Jac	e Le		
6	/Medical Examiner		Tooling in scaliny	Due to (or as a consequence of Chrone	Remol	For On			
		_	Sequentially list conditions,			, —			
	70 ##	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	•				
	ocute and trans	Examiner	that initiated events resulting in death) Last	Meien					
Ç.	ate be executed sysician and he burial-transit		resulting in death, Last	Due to (or as a consequence of);				
09/	ite be iysici iye bu	ical							
9	eath certificate attending phy I for use as the	iclan/Med	is serving					1	
ŏ	n cer andir use	II/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	,		23d. Date of de	•
n	deatl	icla	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time of death	5 ☐ Other (specify) _	<u> </u>		Month	Day Year
o,	at the de by the a tached	Physi	9 ☐ Unknown	9□ Unknown					
J	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions cor	tributing to death but not resulting in t	he underlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires s sigr Id be						1 🗌 Ye	s 2 □ No 3 □ Pr	robably 4 🕅 Unknown
ö	requer peer shou	Completed					24a. Was an	24h Wara au	utopsy findings available
ĕ	e law	np					autopsy	prior to	comptetion of cause of
	: The	S					1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
	vysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?		211		h (Check only one		
/ital F	- 02	은	1 ☐ Yes 2 X No					nce 6 Other (Spe	cify)
Vital	hys his I dii		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injur ury Wor	y at rk?	28d. Describe hor	w injury occurred	
Vital	ng Phys fter this meral dii	5			M 1 🗆	Yes 2 No			
Vital	anding Physiath. Pr. After this ne funeral di	atlon	2 Accident investigation				28f. Location (Str. City or Town,	eet and Number or Ri	ural Route Number,
Vital	r Attending Phys er death. ractor; After this by the funeral dii	tification		28e. Place of Injury - At home, farm	n, street, factory, office	I		Olato)	
Division of Vital F	or Attending Pl ifter death. Diractor; After th in by the funera	Certification	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		,	- State)	
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Vital	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral directal		2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Accident investigation 6 Could not be determined	building, etc. (Specify) sician: To the best of my knowledge, ner: On the basis of examination and	death occurred at the tir for investigation, in my o	ppinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s) th, Day, Year)
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Vital	or Attending Pl ifter death. Diractor; After th in by the funera		2 Accident Investigation 3 Suicide 4 Homicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examilione) 29b. Signature and title of certifier 30. Name and address of person who contains 30. Name and address of person who cont	building, etc. (Specify) sician: To the best of my knowledge, ner: On the basis of examination and and manner stated. Multipleted cause of death (Item 23a) (T	death occurred at the tir for investigation, in my of 29c. Licens ype, Print)	epinion, death occur se number 405 []	and due to the ca red at the time, da	use(s) and manner as te and place, and due id. Date signed (Mont July 11, 2	s stated. e to the cause(s) th. Day, Year)
Vital	or Attending Pl ifter death. Diractor; After th in by the funera	Medical	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) sician: To the best of my knowledge, ner: On the basis of examination and and manner stated. Multipleted cause of death (Item 23a) (T	death occurred at the tir for investigation, in my of 29c. Licens ype, Print)	epinion, death occur se number 405 []	and due to the ca red at the time, da	use(s) and manner as te and place, and due id. Date signed (Mont July 11, 2	s stated. e to the cause(s) th. Day, Year)

Paul Lamont Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04590 State of Maryland / Department of Health and Mental Hygiene RPD For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Paul Lamont Hill 2208 P M 2005 July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 4121 Southern Avenue Suitland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 12≸M 2□F 220-02-6372 30 Yrs. Dec. Wash, Director 1975 16. D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic avant, the Medical Examination ust be notified at 1X Yes 2 ☐ No Director D.C. Washington, D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 230 Rhode Island Ave. #412 NE; 20002 United States Itams 23a Pages 1 and 2 should be filad within 72 hours after death 1 nent of Health and Mental Hygiena. Int: If Itam 27 Is marked othar than "natural", or Itams 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Hill, III Judy Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Rhode Island Ave. #412 NE; Wash, DC. Judy Hardy/Mother 20002 Health Itam 27 I othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If Ita any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial ParkJuly 15, 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Funeral Service Lit 22. Name and Address of Facility 23a. Part1. Enter the disease, shock, or heart failure omplications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner flamy Lossing to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed usa as tha burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 2 (No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No Yes Hospital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 1 XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ ther (Specify) at scene 28c. Injury at Work? 28a. Date of Injury (M. nth, pay 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 2000 M 5 Pending 1 🗌 Yes death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide ace of Injury - At home, farm, street, factory, office building, etc. (Specify) Number or Rural Route Number. 28e filled in by omicide 29a. Certifier Emission: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OCME.

July 8, 2005

111 Penn Street Baltimore Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAURICE HOWARD JULY 2005 12:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY P.G. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAY 1029, 1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F WASH. D.C. 92 579 16 2423 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or itama 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar inset be redified at once. MD. P.G. LANDOVER HILLS Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4804 COOPER LANE 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
15☐ Yes 2 ☐ No
1f Yes, Give 1 0 4 3 / 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: BLACK 3 ☐ Widowed 4 € Divorced Year or Date 1: 943/1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK FED. GOVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN HOWARD MADELIA LEWIS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW HOWARD/SON 4804 COOPER LANE LANDOVER HILLS MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State GLENWOOD CEMETERY 7/15/05 WASH. D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WATSON F. H. 21. Signatur of Funeral Service Licensee 3435 14th ST., N.W. WASH. DC. 20010 23a. Part1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) MRSA PNEUMONIA Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury RESPIRATORY FAILURE Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 1 Yes 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo Certification; To 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) OPMNELL CUMBERBATCH M.D. 3000 HOSPITAL DRIVE, CHEVERLY MD. 20785 32, Registrar's Signature State Registrar

ADH ROBERT VINCENT HILL Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 2005 **Physician** JULY 9, Robert Vincent Hill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 23, 1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1√2 M 2 □ F Washington, DC 45 578-90-1980 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at Director Davidsonville MD Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3444 Blandford Way 21035 U.S.A. Iteme 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2√ No If Yes, Give \(\Lambda\) Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if liem 27 is marked other than eny Injury or other traumatic event, tra Magnes. College (1-4or 5+) Elementary/Secondary (0-12) Private 4yrs Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Wright Barbara Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3444 Blandford Way Davidsonville, MD 21035 Patricia P. Hill/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial 07-15-2005 Davidsonville, MD 22. Name and Address of Facility JB Jenkins Funeral Home 21. Signature of Funeral Service License of D. 7474 Landover Rd Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) · ATHOMOSCISTION CAPOLOVIDSCUM DISCOSE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physiclen and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate hes been signi page 2 should be 1 ☐ Yes 2 ☐ No Completed autopsy death? performed? certificate 1 Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this : After thic To the Hospital or American Swithin 24 hours after death.

To the Funerel Director; After the Funerel Director; After the Funerel Director; After the Funerel Directors and Directors after the Funerel Directors and Directors an

23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of cause of 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3€ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (CHECK ONLY

29c. License number

OCME

State Registrar

Certification:

Medical

JAMANTA 1. Date filed (Month, Day Year) JUL 1 2 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

JULY 10, 2005

1905

 P^{M}

1 TyYes 2 □ No

Approximate Interval Between Onset and Death

20

W

			For State Registrar	State of	Marylar	-	artment of rtificate of		nd Mental Hy	giene Reg. Nő		01.000
			1. Decedent's Name (First, Middle, L	ast)					2. Date of De	ath	- 000	3. Time of Death
	Physici /Medio		MAURICE	W.		HODGE			JULY	10		6:45 A M
	Examin		4a. Facility Name (If not institution, g		oer)		4b. City, Town,	or Location of	Death		. County of Dea	
			PRINCE GEORGE'S		A //	£ 4514 £ 3	CHEVER If Under 1 Year		I Hrs. I a a		INCE GI	
	Funeral Director		5. Social Security Number 6. 577–48–8502	Sex 7. 1-☑ M 2 □ F	Age (in yrs.	last birthday) Yrs.	Months Days		Min. 8. Date of Bir (Month, Da JUNE 3	th ly, Year) 0 19	9. BI	ountry) SHINGTON, DC
ь.			Usual Residence of Decedent					1	JOINE 3	0 17	JO WAL	JIIINGTON, DO
	arylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	88-f	Director	MD PRINCE (GEORGE'S	PA	LMER P	7					1 XYes 2 No
	with t		7605 BARLOW ROAL	`			10f. Zip Code 20785	:			izen of What C	ountry?
	ms 23	Funeral	11. Marital Status	12. Was Deced			Was Decedent of	Hispanic Origin	n? (Specify Yes or No		14. Race - Am	erican Indian,
٥	after or Iter		1 Never Married 2 Married	Armed Forc	X No		f Yes, specify Cu	ban, Mexican, I	Puerto Rican, etc.)		Black, Wh	ite, etc.
15-0036	ral', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2 🙀 No	Specify:			Specify:	BLACK
7	within 72 hours after deeth with the Maryland ene. Than "natural", or items 23a or 28e-f show he Medical Examinar must be notitied at	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		(Give	tent's Usual Occu kind of work done DO NOT use retin	e durina most o	of working	16b. K	ind of Business	s/Industry
717	l withi iene. r than	omp	Elementary/Secondary (0-12)	College (1-4	lor 5+)		al Tech	,		PI	RIVATE	
and	be filed within 72 hours after deeth with the Marylan de Hygiene. de	Be C	17. Father's Name (First, Middle, Las	st)					s Name (First, Middle			· · · · · · · · · · · · · · · · · · ·
<u>Xaa</u>		To	LEONARD HODGE			12		MARTH				
Z Z	7573		19a. Informant's Name/Relationship BARBARA HODGE/WI				-		or Rural Route Numb LMER PARK .			Zip Code) 20785
a)	1 an Heali am 2 ther		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	1	Date		ocation - City o	
ē	Pages nent of int: If its iry or o		1 Surial 2 Cremation 3 4 Donation 5 Dother (Spec		ater	-	natory or other pl. TION CEM	.)	7/15/05			IARYLAND
Baltimore,	그 돈 돈 글 .		21. Signature of Funeral Service Lice						J. B. JE			
ñ	permi Depa Impo any ir		X. D. Ya	should	2	7	474 LAND	OVER RO	OAD LANDOVI	ER,	MARYLAN	D 20785
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cau y one cause on eac	used the deat th line.	th. Do not ent	er the mode of dy	ring, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
-	hysician		Immediate Cause (Final disease or condition resulting in death)	a. 1-191	non	nH9	GIC	S	TROH	(=	-	Onset and Death
	/Medical Examiner		1	Due to (or	as a consec	quence of):		A.10	TROM			
		er	Sequentially list conditions, if any, leading to immediate		as a consec			700	22			ı
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
Ď,	e exe sian ar urial-t		resulting in death) Last	Due to (or	as a consec	quence of):						
9/8	death certificate be executed e attending physician and od for use as the burial-transit	dical		d								
X	eath certific attending p	0 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy					23d. Date of de	liven
ROX POX	death e atter d for a	Physician/M	in the past 12 months?	4□Pregnar	h 2 ☐ Feta ntattime of o		Ectopic pregnand Other (specify)	су			Month	Day Year
J.	by the	hys	9 Unknown	9□ Unknow	m 							
s,	requires that the de een signed by the a hould be detached t	by	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying cause g	iven în Part I.				o the cause of death?
ecords	een soulc	eted							'_'	Yes 2	□No 3□P	robably 4 🐧 Unknown
Z Z	W 0 01	ompleted							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
_	sician: The la certificate ha irector, page 2	e Co	25. Was case referred to medical						1 ☐ Yes	2 X No		s 2X No
5	Physician: this certific ral director,	0	examiner?	Hospital:	patient 2] ER/Outpatien	t 3 DOA O		f Death (Check only of ing Home 5 ☐ Resid		6 ∏Other (Spe	aciful
_	D 9 9	n: T	27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Inju	ury at	28d. Describe			Joney
010	r Attending P er death. rector: After i by the funera	catic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	on		,		Yes 2 □ No)			
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	H 28e. Place o	f Injury - At h g, etc <i>. (Speci</i>	ome, farm, str fy)	eet, factory, office	9	28f. Location (: City or To	Street an wn, State	nd Number or F)	lural Route Number,
_	spitel or ours afte ours afte oral Dir filled in		29a. Certifier 1 X Certifying F	hygician: To the h	act of my kny	owladae doat	a conversed at the	time date and	place, and due to the	221122/2	l and mannot n	o stated
	ne Hospitel or Attendin n 24 hours after death. Ne Funeral Director: Af pletely filled in by the fur	edical		miner: On the bas and manne	is of examina	ation and/or in	vestigation, in my	opinion, death	occurred at the time,	date and	d place, and du	e to the cause(s)
	To the Hosl within 24 ho To the Func completely f	Me	29b. Signature and title of certifier				1 '	nse number			te signed (Mon	
	5		- 1				- (D:	5818	12	7	-10-6	5
	Ur		7. 1	completed cause			Print)	λa	CHE	1 4	./ 117	0 -0-
	- C			EORGE 32. Rec	ristrar's Si	ature# -	HOSPITAL	- 0 K	LHE	VERL	y MI	20785
	Sta Registi		31. Date filed (Month, Day Year)	House &	1							

			For State Registrar	State of M	Maryland / De	partmen ertificat			and M	Re	g. No2 ()	0.5	24270
	Physicia		1. Decedent's Name (First, Middle, La Charles S. H	,						2. Date of Death Month July	_	2005	3. Time of Death 12:30au
	/Medic Examin		4a. Facility Name (If not institution, gi Westminster Nurs			V	lestm	Location o	er			y of Death	
	uneral Director			Sex 7 1 M 2 F	Age (In yrs. last birthd 81 Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month Day 12/8/1	923		lace (State or Foreign try) ryland
ryland	how		10a. State 10b. County		10c. City, Town o	r Location						1	0d. Inside City Limits
the Ma	28e-f s	Director	Md. Carro	_1		Vestmir 101. Zip		•		10	ng. Citizen of	What Coun	1 ☐ Yes 2 No
h with	23e or	ai Dir	111 Hook Rd.			101. 24		.157			USA		uy:
ING 21215-UU36 be filed within 72 hours after death with the Maryland	epariment of Health and Medical Hygiene Health and 128 or 28e-1 show montent: If tiem 27 is marked other then "naturel", or items 23e or 28e-1 show my injury or other treumatic event, the Medical Examiner must be notified at the second of t	by Funerai	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tes 2 If Yes, Give Year or Date:	S No	3. Was Deced If Yes, specific Yes		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	Bla	ace - Americ ack, White, ify: Whi	etc.
Z1Z15-UU36 ed within 72 hours aff	then "natur	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12yrs		or 5+)	ecedent's Usua ive kind of wo e. DO NOT us Mainter	rk done a se retired,	luring mos)	t of workin	ng	16b. Kind of 8	Business/Ind	dustry
Maryland Z	ked other l	To Be Co	17. Father's Name (First, Middle, Las Emory S. Hare	1)						(First, Middle, M	faiden Surna	-	
2 should	ls mar	I	19a. Informant's Name/Relationship			•	•		er or Rura	l Route Number,	City or Town	n, State, Zip	Code)
Pages 1 and	it of Health If item 27 or other to		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles S. Hare Jr. 111 Hook Rd. Westminster, Md. 21157 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State										
Haltimore,	epartmen Importent: eny injury	'4 □Donation 5 □Other (Specify) Meadowridge Memorial 7/14/2										Famil	y F.H.Inc.
IN	ysician Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	sed the death. Do not in line.	Λ	e of dying	1	cardiac o	r respiratory arre	st,	٨	Approximate Interval Between Onset and Death
8/60, cate be executed	physician and <u>u</u>	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwin Cause (Disease or Injury that initiated events resulting in death) Last	c	as a consequence of):								
Geath certific	led by the attending ph detached for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										ate of delive	ory Day Year
S, P	s been signed by should be deta	by	Part II. Other significant conditions	contributing to death	n but not resulting in th	e underlying o	ause give	en in Part I			acco use cor		ne cause of death?
	ate has	Completed								24a. Was ar autopsy perform 1 Yes 2	1		osy findings available inpletion of cause of
Of VITA Physician:	r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	r /		(Check only one	1		
o a	After fune	tion; To	1 Yes 2 No 27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of li			8c. Injury Work	4 - 190	2	ne 5 Resider 28d. Describe ho			')
5 6	s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not determined	28e. Place of	Injury - At home, farm etc. (Specify)	street, factory	, office		2	28f. Location (Str City or Town	reet and Num , State)	ber or Rura	l Route Number,
	within 24 hours after deal To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis	sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.							ated. the cause(s)	
Tol	To the comple	Σ	29b. Signature and title of certifier	mo		290	D (33 (8	4	29	Date sign	ed (Month, I	Day, Year) 2005
) (3)a2		30. Name and address of person who	completed cause of	of death (Item 23a) (Ty	Pe, Print) Busik	415	Cer	to	Drive	Re151	13hr	n, MD ZIBC
	Sta Registi		31. Date filed (Month, Day, Year) JUL 12	2005 32. Fai	strar's Signature	South	9						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** July 6, 2005 Hundemer 11:15 p.^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Northampton Manor Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 109M 201F Months Days Director 404-12-3264 84 September 2, 1920 Kentucky Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f ehow 10c. City Town or Location 10a State in Items 23e or 28e-f ehow 10b. County 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 No Director 10e. Street and Number
2004 Rockland Avenue 10g. Citizen of What Country? 10f. Zip Code 20851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white Specify: ğ other treumetic event, If a Mudical Example 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 12 Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Hundemer Beatrice Chapuis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Rockland Avenue, Rockville, Maryland 20851 Rose Marie Hundemer - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/8/2005 Frederick Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home any. 21a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (LONY-BODY TYPE) disease or condition resulting in death) EW-STAGE DOMONTIA VERES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2□ No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 30 No 2 1 🗌 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1/Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Lertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of centific 29c. License number 29d. Date signed (Month, Day, Year) D32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUX 328 Pa WALKORS VILLE MO 21793 RICHARD GONGH 31. Date filed (Month, Day, 32. Registre's Signature State 1 2 2005 Registrar

ĺ			For State Registrar	State o	f Marylar	-	artment of H rtificate of L								
	Physici /Medic		Decedent's Name (First, Midden Roger Earl		ys				2. Date of Death	30 20) 5 '05	2 Time of Death 2			
	Examir		4a. Facility Name (If not institution Calvert Memor:		·		4b. City, Town, or Prince Fr		th	4c. County o		1			
	Funeral Director		5. Social Security Number 215–78–3891 Usual Residence of Decedent	6. Sex ★ M 2 □ F	7. Age (In yrs. 40	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1965	9. Birthp Coun Mar	lace (State or Foreign try) yland			
	Maryland f show	tor	10a. State 10b. Count Maryland Calve			ty, Town or Le					1	0d. Inside City Limits			
	n with the	Funeral Director	10e. Street and Number 5439 Bayview	Ave.			10f. Zip Code 2068	5		og. Citizen of Wi United S		•			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any highty or other treumatic event. Ite Madical Examinar , ust be multipled at ance.	by Funera	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 ☐ Yes	2 _3 No ve	l.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race Black Specify!	, White,				
21215-0036	ithin 72 hou ne. nan "netura e Wouldell E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired	uring most of wo	rking	16b. Kind of Bus					
and 21	d be filed wental Hygier ked other the cevent, to	To Be Cor	9th 17. Father's Name (First, Middle Earl Clyde Hi			Parce	l Post Ca		me (First, Middle, M	Newspape Maiden Sumame,		elivery			
, Maryland	and 2 shoul alth and Me 127 Is mark er treumati	1	19a. Informant's Name/Relation Donna L. Humphi	ship (Type, Print)			ng Address (Street a Bayview A								
altimore,	Pages 1 ament of He ent: If item ury or othe		20a. Method of Disposition 1 Burial 2 Coremation 4 Donation 5 Other (State Met	ropoli	osition (Name of matory or other place tan Funer		kce ²⁰⁰⁵ A		ia v	wn, State Virginia			
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service	#		44	2. Name and Addres	S IS. K	I. POLL R	ebnorre	PA MD	20676			
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60,	ficate be executed physician and is the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	juence of):									
ox 68760,	feath certificate attending phys	//Medical	IF FEMALE: 23b. Was decedent pregnant		23d. Date	of dollars	P.								
P.O. Bo	res that the death signed by the atter I be detached for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 Feta lant at time of coown		Ectopic pregnancy Other (specify)			Month		Day Year			
Records, F	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	inderlying cause give	n in Part I.				e cause of death?			
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on of	ng Ph fter th ineral	H 1	27. Manner of Death 1 Natural 5 Pend	28a. Date (Mon		28b. Time o	(30 DOA	at	lome 5 ☐ Resider 28d. Describe hor		i)			
Division of	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e Place		ome, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural	Route Number,			
	he Hospli n 24 hour he Funer	edical	29a. Certifier 1 ☐ Certify (Check only one) 2 ☑ Medica	ng Physician: To the I Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my op	e, date and place inion, death occu	a, and due to the ca arred at the time, da	use(s) and manr ite and place, an	ner as sta d due to	ated. the cause(s)			
)	To t Within	Σ	29b. Signature and title of certific	, MD			29c. License OCME	number		od. Date signed (Month, E				
	8		30. Name and address of person		se of death (Iter		Print) 1 Penn	Street							
	Sta Registr		31. Date filed (Month, Day, Year) 0 7 2005)	legistra signa	ature &	Sports								

			for State Registrar	State	of Marylai		artment of			ental Hyg	iene		
			1. Decedent's Name (First, Middle	, Last)						2. Date of Deat	h 200	1.Time of Death	
	Physici /Medic		Charles Richar	d Hilton						June 19	Day Ye 2005	12:27 A M	
1	Examin		4a. Facility Name (If not institution	give street and n	umber)		4b. City, Town	, or Location			4c. County of D		
			3130 Sade Court				Hunti					County	
	Funeral		5. Social Security Number	6. Sex 1	7. Age (In yrs 50	. last birthday) Yrs.	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)	
+	Director		212-66-5647 Usual Residence of Decedent	Λ	00					April 2	6, 1955 V	Washington,DC_	
	yland yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits	
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	ath with the Marylan 23a or 28a-f ehow	Funeral Director	10e. Street and Number	o courrey		recoupting.	10f. Zip Cod			11	0g. Citizen of Wha	t Country?	
	23a	ai	3912 17th Stree	t			2073	2			U.S.A.		
	tems	ne	11. Marital Status	Armed F		J.S. 13.	Was Decedent of Yes, specify C	of Hispanic Or uban, Mexica	rigin? (Spe in, Puerto F	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.	
36	illed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28a-f ehow int, the Modeal Examinatious Learedilled at	by Fi	1 ☐ Never Married 2 💹 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	2 X No live		1 □ Yes 2 🔀 1				Specify:	White	
5-0036	"natural",		15. Decedent	Year or	Dates:	16a Dacar	dent's Usual Oc	Supation			16h Kind of Busin		
Ċ	n "na	Completed	(Specify only highes	t grade completed		(Give	kind of work do DO NOT use re	ne durina mos	st of workin	ng	16b. Kind of Busin	ess/industry	
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פ	0 = 0 %	BeC	17. Father's Name (First, Middle,	Last)		July	poo IIIo			(First, Middle, N	Maiden Sumame)	noyça	
Maryland 2	0 0 0 0 0	ToE	George Hilton					Do	rothy	Frank			
a	d 2 should th and Men 7 is marka traumatic		19a. Informant's Name/Relations								City or Town, Sta		
	s 1 and f Health itam 27 othar tr		Donna M. Hilton	(Wife)							, Marylar	nd 20732	
ore	0 = 5		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from		Place of Dispo cemetery, crer	sition (Name of natory or other	olace)	$\operatorname{June}^{^{\scriptscriptstyle D}}$	23,	20c. Location - City	or Town, State	
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Bal	permit. Departi Importi any inj		21. Signature of Fundament Service	cense								lvert, P.A.	
	# C = 4 O		Michael W	Lee								gs, MD 20736	
F			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line.	ith. Do not ent	er the mode of o	tying, such as	s cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition		20 UVS								
	/Medical Examiner		resulting in death) a										
		<u>~</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	OVCHOL OF AS A CORSE	aneuce off.	Yery	190	east	2		5.415	
	nsit	Examiner	Cause (Disease or injury	(D	1. 1. 01	0 5 11	. 00 1		-	T		10.	
,	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):	<u>ulun</u>	1	14/2			10 915	
8760	ate be ex hysician the buria	dicall		Ca P	enph	eral	Vasu	lar	A	Sease		SUNS	
9				52									
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pregna	DOM:			23d. Date of	delivery	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify				Month	Day Year	
о. О	at the	hy	9 🗆 Unknown										
<u>ဟ်</u>	The law requires that the de site has been signed by the bage 2 should be detached	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part	1.		_	e to the cause of death?	
ord	requi	ted						-		1 L Ye	es 2 No 3	Probably 4 Senknown	
ec	law lasb	Completed								24a. Was ar autops	y prior	autopsy findings available to completion of cause of	
Vital Records,		Cor								perform	ned? deat		
<u> </u>	iclan certif	Be	25. Was case referred to medical examiner?	Hospital:						(Check only on		econd Regidenc	
ō	Phyer this ral di	To	1 Yes 2 Alo 27. Manner of Death	1	Inpatient 2	ER/Outpatier 28b. Time o	t 3 DOA	4 N		ne 5 Reside	ince 6 XOther (econd Residenc	
O	l or Attanding Phatter death. Diractor: After the in by the funeral	tlon	1 Astural 5 Pendin 2 Accident investig	g (MC	nth, Day Year)	Injury		njury at Vork? □ Yes 2 □		od. Describe No	w injury occurred		
Division of	deal deal ctor y the	fica	3 ☐ Suicide 6 ☐ Could r	not be	ce of Injury - At I	nome, farm, str				8f. Location (St)	reet and Number o	r Rural Route Number,	
	after after Dira	Certification:	4 Homicide determ		ding, etc. (Spec					City or Town	, State)		
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director,	alC	29a. Certifier 1 Certifyin	g Physician: To the	ne best of my kn	owledge, deat	occurred at the	time, date ar	nd place, a	nd due to the ca	ause(s) and manne	r as stated.	
	n 24 n 24 ha Fu	edical	(Check only 2 Medicel one)	exeminer: On the	basis of examin inner stated.	ation and/or in	vestigation, in m	y opinion, dea	ath occurre	d at the time, da	ate and place, and	due to the cause(s)	
	To the comp	ž	29b. Signature and title of certifier				29c. Lic	ense number		25	9d. Date signed (M	onth, Day, Year)	
)			Calter C	Moun	m	Mar	3 D	458	35		June 20,	2005	
	5		30. Name and address of person			m 23a) (Type	Print) Cath						
	5		10845 TOWN	Center	BIVD =	# 203	, Da	nkiv	10	MP	20154		
	Sta Registi		31. Date filed (Month, Day, Year)	2 1 2005	Hegistra's Sign	ature	-1 -	4					
	negisti	वा	3311		V ASTABLA	KI SS.	LOGICE						

į			For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hy	giene	05 24275			
	Physici		Decedent's Name (First, Middle, Last, Donald Willis JER					2. Date of Dea		Year 3. Time of Death 3:13 P M			
	/Medic Examir		4a. Facility Name (If not institution, give Washington County			4b. City, Town, o	r Location of Dea	ath	4c. County of				
	Funeral Director		240-00-7203	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, 1942	9. Birthplace (State or Foreign Country) South Carolina			
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	3a or 28a-	Il Direct	10e. Street and Number 700 Toll House Av			10f. Zip Code	21	L701	10g. Citizen of W	hat Country?			
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Mudical Exar.	Completed by Funeral Director	11. Marital Status 1∑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No		Specify Yes or No- rto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. white			
1215-0	vithin 72 ho ne. han "natur e Medicel	mpleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of w d)	orking	16b. Kind of Bus	16b. Kind of Business/Industry			
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I's Ma	To Be Co	6 17. Father's Name (First, Middle, Last) Arthur Willis Jen	nigan	ē	never em	18. Mother's Na	ame (First, Middle, Haynes	Aiddle, Maiden Sumame)				
	1 and 2 should Health and Men Iem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Thompson Funeral h	nome	1012	Whitman	St., Ora		S. Caro	lina 29115			
Baltimore,	Pant Ind.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Has	gerstov	sition (Name of natory or other place on Cremat	ory 7/3	Date L5/05		own, Maryland			
Bal	permit Pag Department Important: any injury 6		21. Signature of Feneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Bet										
1760,	hysician by hysician and hysician transit tran	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): 6	train	u a	Œlai (Approximate Interval Between Onset and Death			
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE:	d	Ideath 3	Ectopic pregnancy	,		23d. Date Moni	of delivery th Day Year			
rds, P	quires that an signed b	by	Part II. Other significant conditions con				en in Part I.			oute to the cause of death? B Probably 4 Unknown			
I Records,	The law re ate has bee page 2 sho	Completed	Morain Ala	tal Shure	<i></i>			24a. Was a autop perfor	sy pr med? de	ere autopsy findings available ior to completion of cause of eath? Yes 2 \sum No			
Division of Vital	Hospital or Attending Physician: 4 hours altar death. Funeral Director: After this certific ely filled in by the funeral director.	edical Certification; To Be C	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 7. Manner of Death 5 Pending investigation 6 Could not be determined	sician: To the best of my kno	28b. Time of Injury 1200 ome, farm, str	28c. Injur Wor 1 □ eet, factory, office	y at k? Yes 2 ANo	ence 6 Other ow injury occurre ow in State) ause(s) and man	(Specify) d a un whee / Clar or Rural Route Number, 2170 (ner as stated.				
)	To the within 2 To the complete	Med	29b. Signature and the of certifier School of Certifier 30. Name and address of person who co), Di Ho 7	23a) (Type,	29c. Licens	e number	2	29d. Date signed Tuly 1 Happens	(Month, Day, Year) 3, 2005			
-8-3	Š Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	19 011 H. A.	pules	- terror	LBL	2174	2			

			1 - For State Registrar	State of M	arylar		artmen rtificat			ind M	•	giene Reg. N	005	26276		
	Physici /Medio		Decedent's Name (First, Middle, La. VERNA	st)		J	OHNSO	N			2. Date of De Month 07	Day 05	2005	3. Time of Death 5:10A. M.		
	Examir		4a. Facility Name (If not institution, giv. MARINER HEALTH (F FOREST	HILL			FORE	Location o	LL]	Day 2005 3. Time of Death 5:10A. M. 4c. Country of Death HARFORD Year 3 9. Birthplace (State or Foreign Mary I and Death State or Foreign Mary I and Death HARFORD Year 3 9. Birthplace (State or Foreign Mary I and Death Country) I and Death Dea			
	Funeral Director		5. Social Security Number 6. S 217-01-1378 1 Usual Residence of Decedent	ex 7. Ag □ M 2∏ F	91	last birthday) Yrs.	If Under Months		Hours	Min.	8. Date of Bir (Month, Da NOV. 6	, 1°91	9. Birth Cou Mar	place (State or Foreign intrx) y 1 a n d		
	e Maryland le-f show lilied al	ctor	10a. State 10b. County Maryland Harfo	r d	10c. Cit	ly, Town or Lo	cation Fore	st H	[i11	-						
	th with th	ai Director	10e. Street and Number 2398 Edwards	Manor			10f. Zip		1050			10g. Citize		intry?		
980	72 hours after death with the Maryland "netural", or Items 23a or 28e-f show olical Exercities from the nutilised at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	Ever in U No		Was Deced f Yes, spec 1 ☐ Yes			in? (Spe Puerto	ecify Yes or No Rican, etc.)	ŀ	Black, White,	, etc.		
Maryland 21215-0036	within 72 hou ene. then "nature ne Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)		kind of wo DO NOT u	rk done d se retired,	tion luring most		ng	16b. Kind of Business/Industry Seafood Packing				
yland 2	2 should be filed and Mental Hygid Is marked other eumatic svent, II	To Be C		ander	Foo	ote			18. Mother	rs Name arl	otte	A .	Bish	1		
	1 and Health tem 27 other tr		19a. Informant's Name/Relationship (Gregory Johns 20a. Method of Disposition	on/son	20b. F	1	Edwa	ards	Man	or		rest	Hill	,MD 21050		
Baltimore,	permit. Pages Department of i Importent: If It any injury or o		1)		. John	n ÚM(Name an	C Ce	m. 7	Se	well F	uner	al Hor	me		
	Medical Examiner The buriar transit	Examiner	23a. Part1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of Injury that intitated events resulting in death) Last	one cause on each III	a conseq	uence of):							we	Interval Between		
P.O. Box 68760,	it the death certifi by the attending I tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	2 Feta	ldeath 3 eath 5	Ectopic pr	ecify)				23		•		
ຜົ	requires een sign nould be	by	Part II. Other significant conditions of	ontributing to death b	ut not res	uiting in the ur	nderlying c	ause give	n in Part I.		101	Yes 2		1		
Vital Record	The larate hes	e Completed	25. Was case referred to medical						76 Plane	of Dooth	24a. Was autop perfo 1 Yes	orned? 2 No	prior to co death?	empletion of cause of		
of	ys di	ation: To B	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: A Nur	sing Hon	ne 5 Re <i>s</i> id	dence 6		(y)		
Division	in Dir	Certification:	3 Suicide 6 Could not be determined	building, et	c. (Specify	v) 					City or Tox	vn, State)				
	To the Hospitel within 24 hours a To the Funeral completely filled	Aedicai	one)	vsician: To the best of iner: On the basis of and manner sta	examina	wledge, death tion and/or inv	estigation,	in my op	inion, death	place, a occurre	nd due to the od at the time,	cause(s) ar date and p	nd manner as s lace, and due to	stated. the cause(s)		
	Mith To Con	×	29b. Signature and title of certifier	2	_			. License	number	55		-				
	3		30. Name and address of person who o				P <i>ri</i> nt)				014		//_			
	Sta Registr		31. Date filed (Month, Day Year)	8 2005 Registra	Signa	ture	-									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND TTRM#5 per INF G863 176/07 WS State of Maryland 7 Department of Health and Mental Hygiene

				State of Mary	ylanu / i	•	ificate of		•	Reg. No. 2	05	210) " "		
			1. Decedent's Name (First, Middle	, Last)		-			2. Date of De	eth	00	3. Time of	Death		
- 100	Physicia /Medica		Dean 1	Maurice	Jo	hns	on		July	10, Day 200	05 ^{ar} 1	0:45	Am		
	Examine	er	4a Fecility Neme (If not institution, Heartland Man					4b. City, Town, or I Adelphi	ocation of Deet	Mont (- y	_		
	Funeral Director		5. Social Security Number 306-66-4212 Usuel Residence of Decedent	6. Sex 7. Age (li	n yrs. last bii 47		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Pa 0 9 - 2 4	th 1975 7	9. Birthpl Count Indi	ace (State or ly) ana	r Foreign		
	Meryland f show	5	10a. State 10b. County	e George	Oc. City, Tow			Height	S		10	od. Inside Cit	•		
	uth with the Merylar 23s or 28s-1 show ust be notified at	Funeral Director	10e. Street end Number 404 Quarry Av	ve.			10f. Zip Code 2 0 7	43		10g. Citizen of V		ry?			
020	urs after des	^	11. Maritet Status 12 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? ed 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ir in U,S.		s Decedent of H es, specify Cuba Yes 2 12 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rac Blac Specify	ce - America ck, White, e y: Bla	itc.			
21215-0020	within 72 he ene. than "natul he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+)	1		nt's Usual Occup nd of work done O NOT use retired ter Of	ation during most of word)	king	16b. Kind of B		ustry			
22			17 Fathada Nama /Fins Middle 1		MI	nıs	Ler or		- /Fi Adi-t-ti-	Priva					
Maryland	wild be fi Mental H irked oth		17. Father's Neme (First, Middle, L Sterling Jo	18. Mother's Nam Vivian		Stepher									
	und 2 sho alth and 1 27 la me ir traume	1	19a. Informant's Name/Relationsh Sterling Johns		19b ther	. Mailing 279	Address (Street Earl	and Number or Ru Slate Re	re/Route Numb 1. Clar	er, City or Town, rksvill	State, Zip (Le, T	Code) 'N 37(043		
Baltimore,	Pages 1 and of He net: If Item		20a. Method of Disposition 1 ☐ Burial ②□Cremation 4 ☐ Donation 5 ☐ Other (Sp.	7-18-	20c. Location -										
Balti	permit. Departm Importar any inju		21. Signature of Puneral Service L	icensee	ss of Facility [a	lor's				2002					
T.		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Betw Onset and D	reen		
and the second	Physician /Medical Examiner		Immediate Ceuse (Finat disease or condition resulting in death)	CERE	BRI	AL	ED	EMA	ı		1 1	011301 0110 0	ou.		
		lue.	resulting an dealtry	STATU	e to (or as a			TICVI			1				
oʻ	an end	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		o to (or as a	conseque	ince of):			DEFINI	F174				
κ 68760,	E 20 8	5	that initieted events resulting in death) Last	d. TOXOPL	to (or as a o	conseque	nce of):			22170	cry	-			
Box	eath cer attendir I for use	30		a.70/010	7.37	.0-31		010/102	1113						
0	the at	ruysician/n	Part II. Other significant condition	e contributing to death but no	ot resulting in	n the und	erlying cause giv	en in Pert I.	23b. Did	tobacco use cor	ntribute to	the cause o	f death?		
s, P.O.	v requires that the death ce been signed by the attendi should be deteched for use	Dy Pm				_			1 🗆	Yes 2 No	3 ☐ Probe	ably 4⊡t	Inknown		
ecord	e law require hes been si ge 2 should	Completed							24a. Was perfo	an autopsy med?	avai	re autopsy fir lable prior to apletion of ca eath?	_		
Œ	The I	5							10	Yes 20 No	10	Yes 201	No		
Vita	clan: entific ector.	9	25. Wes case referred to medical examiner?	Ha-ial			0.11	26. Place of Dea	th (Check only o	ne)					
n of	ng Physician: viter this certific uneral director,		1 Yes 2 No 27. Manner of Death 1 Naturet 5 Pending	Hospital: 1 Inpatient 28a. Dete of Injury (Month, Dey Ye	2 ER/Ou 28b. 1	tpetient Fime of njury	3□ DOA Oth	y at k?		dence 6 Other					
Division of Vital Records,	or Attanding siter death. Director: After in by the fune	5 \$ 5 E L Specify)									28f. Location (Street and Number or Rural Route Number City or Town, State)				
_	To the Hospital within 24 hours e To the Funeral Completely filled	edical Ce	29a. Certifier (Check only one) Certifying Certifying Condition Certifying	Physician: To the best of m	amination and	, death o	ccurred at the time tigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as sta and due to t	ited. the cause(s)			
	o the	_	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d. Date signer	d (Month, D	ay, Year)			
	->-0		Chardre	sekhar Fis	whit.	MD		2855							
	33	- 1	30. Name and address of person w				nt) 72	EEN 3	NOVER	M.D 2	分で	3			
	State Registra		31. Date filed (Month, Day, Year)	32. Registrer's				Property Co.	terito i		a three media.				

				partment of Health and Menta ertificate of Death			
	Physici	an	1. Decedent's Name (First, Middle, Last) GERTRUJE KING	2. Dat Mo		ZUU5 ay Year	3. Time of Death 8
>	/Medio Examin	er	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST MOSPITAL	4b. City, Town, or Location of Death ROLK VILLE	4	c. County of Death	
	Funeral Director		5. Social Security Number 213.46.8325 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 2 rs. 84	/) If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mo	te of Birth onth, Day, Year L. 10,	r) 9. Birth Cou 1920 Mary	place (State or Foreign intry) yland
	Maryland -f show fied at	tor	10a. State 10b. County 10c. City, Town or L	ocation hersburg			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Director	10e. Street and Number	10f. Zip Code		citizen of What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show apportant: If item 27 is marked other than "natural", or Items 23e or 28e-f show appropriately injury or other traumatic event, it is Madical Examiner must be multiple at once.	by Funeral	811 Quince Orchard Blvd. #14 11. Marital Status 1 Never Married 2 Married 3 \ Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 \ No Yes 2 \ No Yes 3 \ No	20878 . Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:		S.A. 14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	within 72 ho ane. Ihan "natur e Madical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Ir	
land 2	ild be filed v fental Hygie rked other i ilc event, II	To Be Co	5th Home 17. Father's Name (First, Middle, Last) Unknown	Middle, Maide	Domesti an Sumame)	ic	
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Unknown ling Address (Street and Number or Rural Route			
Baltimore,	Pages 1 ar		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	4 Old Columbia Pike. S consistion (Name of ematory or other place) Heaven Cemet. 07/19/20	20c. l	Location - City or T	own, State
Baltii	permit. F Departmo Importar any injur		-Rinald	i Funeral	ng, MD L Home, Inc. g, MD 20904		
8760,	Cate be executed /Medical Examiner und fitte brital-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respin	ratory arrest,		Approximate Interval Between Onset and Death ON WEEKS
.O. Box 68	death certifi e attending i id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
۵.	quires that the n signed by th uld be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	3e. Did tobacco	use contribute to t	the cause of death?
Vital Records,	sician: The law requires certificate has been sign rector, page 2 should be	e Completed	25. Was case referred to medical	10	a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Division of Vil	iing Phys n. After this funeral di	To B	examiner? 1 Yes 2 No	of 28c. Injury at 28d. De			(fy)
Divi	ital or Attandurs after deathral Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	Cit	ty or Town, Sta	•	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	ledicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due nvestigation, in my opinion, death occurred at the	ne time, date ar	nd place, and due t	to the cause(s)
)	To with	Σ	29b. Signature and title of certifier ASIT P. ICURUNU	29c. License number 3 46187	29d. D.	ate signed (Month.	Day, Year)
_	•		30. Name and address of person who completed cause of death (Item 23a) (Type ATIT P. KURUVIUA MO 111)	RUCKVILLE PILE, HOO	& Rocy	KUKLE	MD 2080
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barle	1	,	

Ellen Marsha Kaufman 05-04576 NJM

-04576 M		For State Registrar	State of I	Maryland // D		artment of tificate of				giene Reg. No.	005	242	79	
Physici		1. Decedent's Name (First, Middle, La Ellen Marsha Ka							2. Date of De Month July		Year 2005	3. Time o		
/Medio Examir		4a. Facility Name (If not institution, given Route 50 at mil	e street and numb			4b. City, Town, West	or Location		oury	4c. County of Death Anne Arundel				
Funeral Director			Sex 1 □ M 2/2/F	Age (In yrs. last birt	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da July 23	Day, Year) Country)					
death with the Maryland ms 23a or 28a-1 show rmst be notified at	ector	10a. State 10b. County MD Montgome	ery	10c. City, Town						10d. Inside City Limits 1 — Yes 2 □ No				
with the or 2	Dire	10e. Street and Number 203 Jersey Land	2			10f. Zip Code 208.	50				on of What Coun	,	Amorio	
in the second	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∍s? F 3 No		Was Decedent of f Yes, specify Cu	Hispanic Or ban, Mexica		ecify Yes or No Rican, etc.)	- 14	Race - Americ Black, White, pecify: Whi	an Indian, etc.	ZINCI IC	
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. 0 00	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ■ Inknown		h 2 ☐ Fetal death nt at time of death		⊒Ectopic pregnan ⊒ Other (specify)	су		(14 14 14 14 14 14 14 14 14 14 14 14 14 1	23	d. Date of delive Month	ery Day	Year	
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DIVISION To the Hospital or Attend within 24 hours efter death To the Funarel Director: completely filled in by the		4 ☐ Homicide determine 29a. Certifier 1 ☐ Certifying F	building	g, etc. (Specify) est of my knowledge	y (h occurred at the	time, date a	nd place,	and due to the	cause(s) a	nd manner as si	tated.		
he Ho in 24 h ha Fu pletely	edical	(Check only 2 Medical Exa	miner: On the bas	is of examination an	d/or in	vestigation, in my	opinion, de	ath occur	red at the time,	date and p	lace, and due to	the cause	(s)	
To the within 2 To the complet	2	29b. Signature and title of certifier	M	14-			nse number CME				8, 200			
10		30. Name and address of person who	,	of death (Item 23a)	(Туре,	Print)		Stree	t Balt		e, Maryl		21201	
St Regist	ate rar	31. Date filed (Month, Day, Year)	ord D	gistrar's Signature	dos	ule								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year **Physician** July 7, Celia Kaiser 12:58AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 0 CT. 30, 1909 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign New York 10 M 20 F Director 061-05-3017 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or their traumatic event, the Medical Event near the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 8750 Georgia Ave. #411B 20910 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ANo Specify: Specify 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Milliner Millinary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isaac Weiss Rachel Morganstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Kaiser- Step Daughter-3100 N. Leisure World Blvd. #501 Silver Spring, MD 20c. Location - City or Town, 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Judean Memorial Garden 07/10/05 Olney, Maryland 21. Signature of Funeral Service Licensee Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Myocardial Infarction Days /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Coronary Artery Disease Due to (or as a consequence of Examine inding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months? 1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4X Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 XNo certificate 1 ☐ Yes 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only onel within 2 title of certifier 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D - 32332 July 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, MD 9801 Georgia Ave Suite 220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1- For State of Maryland / Departm	ent of Health and Mer	ntal Hygien	21115 21.201
			Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Death	4	c. County of Death
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alti	permit. Departri Importe eny inju		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility	1 1	
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Division of Vital Record	Attending Physicien: r death. ector: Atter this certific. by the funeral director,		27 Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury		Describe how inju	
<u>0</u>	ttendir death. stor: Al	atic	2 Accident investigation M	1 ☐ Yes 2 ☐ No		
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			and 2 Event 7108 17 0 amp	Usus Che	· tr. M	02/4/9
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	Registr	ar	The state of the s			

Physician /Medical Examiner

Funeral Director

parmit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mantal Hygiana. Important: If them 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at page.

Baltimore, Maryland 21215-0036

Le, ban Ngoc

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the bunal-transit

	State of I	Maryland / Depa	artment of rtificate of		, ,				
n	1. Decedent's Name (First, Middle, Last)	- 00	rimeate of	Doan	2. Date of Dee	th Dey	05 Year	Time of Death)
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medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
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10.00	examiner? 1 Yes 2 No Hospital: 1 Inpa 27. Manner of Death 28a. Date of It		1 3LI DOA	ther: 4 Nurs	f Death (Check only on ing Home 5 Reside 28d. Describe ho	ence 6 □Oth)	_
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	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner and manner	of examination and/or in	n occurred at the t vestigation, in my	time, date and opinion, death	place, and due to the co	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)	
	29b. Signature and title of certifier	0/2	29c. Licer	nse number	3642	9d. Date signer	620	205	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Sta Registr

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Toshiko 0.5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery 7. Age (In yrs. last birthday)
7.5 Yrs. Months Days Hours Min. Feb. 4, 1930 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF 220-38-7525 Director Japan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "naturel; or items 23s or 28e-f show any injury or other traumatic event, if a Marylan Examination at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ¾IXNo Director Virginia Loudoun South Riding 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42996 Center Street 20152 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 24 No Specify: Asian Specify: δ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unobtainable Unobtainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sean Fritts - Grandson 42996 Center Street South Riding, VA 20152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 7-10-2005 Fairfax Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Fairfax, Virginia 22. Name and Address of Facility EVERLY FUNERAL HOME 21. Signature of Funeral Service Licensee Yare Malue 10565 Main Street Fairfax, VA 22030 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near tailure. Sist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) ATHEROSUE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ██Ño Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ commen morn 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has l page 2 s performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after users... To the Funerel Director: / 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 000 58776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mosternam, D.C. vannum No 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

3. Registrar's Signature

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 3:12 P^M EDNA WELLENS LUNSFORD July 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)

March 27,1905

9. Birthplace (State or F Country)

Pittsburgh, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1□M 2ĀF Days Hours Min Yrs. Director 579.30.4555 100 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and I health and Mental Hygiene and I hear 27 is marked other then "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1XYes 2□No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17737 Stoneridge Drive 20878 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or5+) Years Elementary/Secondary (0-12) Administrative Supervisor U.S. Government traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry William Albert Wellens Mary Preuss ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Smith Tarchalski/Niece 17737 Stoneridge Drive, Gaithersburg, MD 20878 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportent: If iter any injury or oth once. 1 Burial 2 □ Cremation 3 □ Removal from State 07/08/2005 Brentwood, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Fort Lincoln Ceme. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904 Na 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Acute Myocardial Infarction Approximate Interval Between Onset and Death Acute Myocardial Infarction **Physician** Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Days Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Advanced Dementia Years Due to (or as a consequence of): burialas the burial Box 68760 Physician/Medical attending IF FEMALE esn. 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Be Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has certificate 2□ No Division of Vital 1 Tyes 2 No 1 TYes the Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funerel (hours 29a. Certifier 1 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Tigg Certifying Friffsteen: 10 the best of my knowledge, death occurred at the line, date and place, and due to the cause(s) and manner stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 ပ 7-3-05 A. Nauen D50987 30. N and address of person who completed cause of death (Item 23a) (Type, Print) mo 20883.

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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33819

GAITHRSBURG

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2. Registrar's Signature

NAWAZ

2005

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State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. NoZ U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEATH. ELMER 4.38 A-M 2005 Juli /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CRESCENT CITIES CENTER RIVERDALE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nove | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X**M 2□ F Yrs. Director 411-34-3002 78 DEC. 4, 1926 TENNESSEE Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No MD. PRINCE GEORGES HYATTSVILLE Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 43rd ST. 6118 20781 U.S.A. filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Amed Folces.

1 Yes 2 No
If Yes, Give 1950—
Year or Dates: 1954 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 📉 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 SPECIAL EVENTS PEPSI COLA CO. permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Importent: If item 27 is marked other it
any injury or other treumetic event, In
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္ MARGARET **TAYLOR** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA J. LEATH/WIFE 6118 43rd. ST., HYATTSVILLE, MD. 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 TCremation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY 7-9-2005 RIVERDALE, MD. 21. Signature of Funeral Service Lieshsee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 207 M00091 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aronthuias Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate ha 2□ No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 48213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NECLAM AShou 4410 74th Ave landovertills MD 20784 74th Ave 4410 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature 1 1 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | State of S Certificate of Death 2. Date of Death **Physician** Month 0326AM argaret /Medical 4a. Facility Name (Mont institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMBRIDGE CAMBRIDGE GENERAL HOSPITAL DURCHESTER DORCHESTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K F Hours TYrs. 266-54-587 Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other then "neturel", or Items 23s or 28s-f show other treumatic svent, the Medical Evantinar must be notified at 1 Yes 2 No Directo Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 4455 Ka SA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 hand Menta! Hygiene.
7 le marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Field Worker Migrant Field Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Unknown Annie Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 le n any injury or other treun Carlton Nuton-Nephew Maryland 21643 4455 Preston Rd. Hurlock, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Preston, md n's Cemeter 4 07-14-2005 21. Signal ye of Juneral Service Licensee 22. Name and Address of Facility Bennie Smith Funera 516 S. Main Street Hurlock, md. 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or and considering of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit be executed Causa (Disease or that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IE EEMALE esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? for Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 the a detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/4 To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 SER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number H0062554 30. Name of d address of person who completed cause of death (Item 23a) (Type, Print) snen Street, Cambridge, maryland 21613 CYNTHIA 300 B 31. Date filed (Month, Day, Yaar) 2085 Registra Signature State Registrar

			1 - For State Registrar	State of Maryland	d / Depa		lealth and	Mental Hyg	iene	005	21,207	
	=		Decedent's Name (First, Middle, Last)					2. Date of Deat	th		3. Time of Death	
	Physici /Medio		THOMAS EAR	L MILLER				July	Day 12	Yeer 2005	04:41 M	
	Examir	_	4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Deat	h	4c. Cour	ity of Death		
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	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)			
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far,	a se se		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Number	City or Tow	n, State, Zip	Code)	
			Jean Miller	wife	321	Vale Stre	et, Hage	rstown,	Maryla	nd 217	740	
ore	or other		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R		lace of Dispo	sition (Name of natory or other pla		Date 20c. Location - City or Town, Stete				
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760,		icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	CANC				·	Interval Between Onset and Death MK N WYY	
Records, P.O. Box 68 The law requires that the death cardifical	igned by the attending pt be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy		Date of delive Month	ny Day Year			
<u>ا</u> و	ned b	y PI	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	acco use co	ntribute to th	e cause of death?	
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Division of	er this neral dir	F :	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		y at	28d. Describe ho			,	
ס פֿ	death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOTH, Day Toll)	Injury		Yes 2 □ No					
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Ę	Within To the comp	Σ	29b. Signature and title of certifier	Zi.		29c. Licens	e number	2	9d. Date sign	ned (Month, I	Day, Year)	
•			1 Kills	ah i	nD	00	5818	1	71	13/2	005	
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)						
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	Sta Registi		31. Date filed (Month, Day, Year)	32. Regetrar's Signal	dure.	mutes						

LEILLIA MCGEE 05-04869 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	<i>B</i> (1)		1 - For Unpend Item 23 Registrar 1. Decedent's Name (First, Middle, Last)	awzy per	The G840 &	rtificat	e of l	Death				2005	242	88
₹.	Physici		Letitia Jo McGee							2. Date of De Month JULY		8, 2005	3. Time of De 4;40P.	eath M
	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location of	of Death	_0011		County of Death		
		41.	150 WALTON LANE				RTH E					CECIL		
	Funeral Director		5. Social Security Number 212-02-0455 Usual Residence of Decedent	7. Age	9 (In yrs. last birthday 37 Yrs.	Months	Months Days Hours Min. 8. Date of (Month), Augus					Cou	place (State or F intry) MD	₹oreign
1	yland		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City	Limits
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	with the	Funeral Director	10e. Street and Number			10f. Zip					-	izen of What Cou	intry?	
	ne 23	erai	150 Walton Lane	12. Was Decedent B	ever in U.S. 13.		1901 dent of H		gin? (Spe	ecify Yes or No		SA 14. Race - Amer	ican Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show important: if item 27 is marked other then "naturel", or items 23a or 28a-f show propriaty high or other treumatic event, the Medical Examinar must be codified at DRCs.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	lo	If Yes, spe		Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, White Specify: Whi	, etc.	
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, Maryland	and 2 sho salth and I n 27 ie mu		19a. Informant's Name/Relationship (Ty Willie Joe McGee/16 Alice Marie McGee/1	_{рө, Print)} uther nother	150	Walto	n La	and Numbe .ne, N	or or Rura		er, City o	r Town, State, Z. 21901	p Code)	
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Ba	Dep impe		23a. Party. Enter the disease, or compli	cu		11 S.	Que	en St	reet	, Risin	ıg Sı	in, MD	me, P.A 21911 Approximate	•
	Physician /Medical Examiner	iner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury	Probable Due to (or as a	e Cardiac a consequence of):	Arrytl	nmia						Interval Betwe Onset and De	en ath
68760,	icate be executed physicien and sthe burial-transit	dical Examiner	Cause (Disease of Highly that initiated events resulting in death) Last		a consequence of):									
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of	ding Phys h. After this tuneral di		27. Manner of Death	28a. Date of Injur (Month, Day			8c. Injury Worl	4 🗀 190		28d. Describe			ry) DOLLIND	
sior	Attending Physician: r death. ector: After this certifica by the funeral director, I	atio	1 Natural 5 Pending 2 Accident investigation	(Monin, Da)	Year) Injury	М		Yes 2 🗍	No					
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding. etc.	ury - At home, farm, s :. (Specify)	treet, factor	, office			28f. Location (City or To	Street an wn, State	d Number or Rui)	al Route Numbe	Г.
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in the compl	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Madical Examination	sician: To the best of her: On the basis of and manner sta	of my knowledge, dea examination and/or i ited.	th occurred nvestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier **Famula Lycidilal Section 1.15	ul, mi		290		·M.E.				19, 200		
			30. Name and address erson who co	mpleted cause of de	eath (Item 23a) (Type		PENN	STRE	ET, B	ALTIMO	RE,M	ARYLAND	21201	
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			-			,			
DH	Regist		JUL 2 1 2005	Marie	I Apr									

.K	S		Please T	ype or Print in Black	Indelible Ink. Ensure A	II Copies Are	Legible.	
AYI	VARD DA	VII	MINOR State		epartment of Health and N	lental Hygien	e	
20	grade 1 Tab		State Registrer 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No.	2005	21, 200
	Physici /Medic		Raynard Davi	d Minor		Month Da	2005	04:32 AM
	Examin	er	4a. Facility Name (If not institution, give s SUBURBAN HOSPITAL		4b. City, Town, or Location of Death BETHESDA	40	c. County of Death MONTGOME	
4	Funeral Director		5. Social Security Number 5555-77-7673 6. Sex 15	36	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year April 15	19 9. Birthp Cour , 69 Loui	lace (State or Foreign itry) Siana
	Maryland a-f ehow	tor	10a State 10b. County	10c.City.Town Washi	or Location ngton		1	0d. Inside City Limits
	h with the 23a or 28s	ai Director	1205 7th Stree	t N.W. Apt 404	10f. Zip Code 20001		S.A.	try?
036	d within 72 hours after death with the Maryland Jiene. r then "netural", or Items 23a or 28s-f ehow the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:Blace	etc.
21215-0036	within 72 ene. then "ne!	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed)	Decedent's Usual Occupation (Give kind of work done during most of work life 00 NOT use retired US COMET SERVICE	rina .	Kind of Business/Indetail	dustry
Maryland 2	be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last)		Mary	Lee Mino	r	
	d2sh thand 7 ism traum		19a informant's Name/Relationship (Ty Mary Lee Gray-	Mother 19b.	Malling Address (Street and Number or Run 307 Michelli Dr I		or Town, State, Zip ge Louis 708	Code) jana 7
Baltimore,	t of if it		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State 20b. Place of scemeter Sout	nern Memorial dens	716,05 Ba	Location - City or To ton Roug	wn, State Je, La
Bal	permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Lice	Llunds	22. Name and Address of Facility Robinson Funera 1313 6th St. N.	al Home W. Washi	ngton, I	D.C.20001
	Physician		shock, or heart failure. List only of trimediate Cause (Final	ne cause on each line.	tot enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	victies And Compres	210 vol 020	Niki e	100
	outed a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	ort):			
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rds, P.	The law requires that the tte has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co.	ntributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the	
il Records,		Completed				24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of 2 \square No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 XER/Ou	Other	th (Check only one)		
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Division	or Attentiter deat	Certification:	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Location (Street a	and Number or Rura	I Route Number,
	9 4 4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	edical (29a. Certifier (Check only one) 1□ Certifying Phy 2X Medical Exami	sician: To the best of my knowledge iner: On the basis of examination an and manner stated.	o, death occurred at the time, date and place, dror investigation, in my opinion, death occur	, and due to the cause	(s) and manner as s nd place, and due to	lated. o the cause(s)
	o the o the o the omplet	×	29b. Signature and title of certifier	O -	29c. License number	29d. [Date signed (Month,	Day, Year)

State Registrar

111 Penn Street Baltimore, Maryland 21201

			1 - For State Registrar	State of Marylar	id / Depa	artme		alth and		tal Hygi	_		24290
I	Physici /Medio			essa Murphy		ı			Ju	Date of Death Month 1y 10,		Year	3. Time of Death 1:00A M
	Examir	er	4a. Facility Name (If not institution, give s Prince George Hos	pital		Che	everly	ocation of Deat				ty of Death ce Geo	
	Funeral Director		5. Social Security Number 6. Sex 577-40-2245	7. Age (In yrs. 74	last birthday) Yrs.	Month		If Under 24 Hrs Hours Min.	7	Date of Birth Month, Day, 1	^(ear) 1930		lace (State or Foreign try) Sylvania
	Maryland a-f show	tor	10a. State 10b. County Maryland Prince G		ty, Town or Lo		ngs					1	0d. Inside City Limits 1√2 Yes 2 □ No
	h with the 23a or 28	ai Direc	10e. Street and Number 6608 Howie Court			10f. 2	ip Code 2074	48		_		What Coun	•
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show may highly or other treumatic event, if a Madical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	I2. Was Decedent Ever in U Armed Forces? 1			edent of Hisp ecify Cuban, 2🖾 No	panic Origin? (S Mexican, Puerl Specify:	pecify o Rica	Yes or No- n, etc.)		ace - Americack, White, ify: B1	
215-0	thin 72 ho e. an "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of v DO NOT		ring most of wo	rking	16	3b. Kind of I	Business/Ind	dustry
Maryland 21215-0036	should be filed withir de Mental Hygiene. marked other than imatic event, Itel	Be	Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last) Unknown	2	Enrol	llmer	t Clei	8. Mother's Nar		st, Middle, Ma			ernment
Maryla	d 2 should be h and Mental 7 is marked of treumatic ev	Ը	19a. Informant's Name/Relationship (Typ. Joan Bryant/Daught		19b. Mailin	ng Addre	ss (Street and	Janie] d Number or Ru rt; Cam	ıral Ro	ute Number, (City or Town	n, State, Zip 2074	
	ges 1 and of Healt If item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Dispo	sition (N	ame of		Date			- City or To	
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 Is any Injury or other tre <u>QDCB</u> .		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Figure 3 Service License	Har	A 4		ial Pa and Address	rk July of Facility		2005 e Fune 8 Marll estvil			MD.
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Vital		Be Co	25. Was case referred to medical examiner?	,		Y		6. Place of Dea		1□ Yes 2〔		1 Yes	2 No
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Division	I or Attending Physicien: after death. Director: After this certific I in by the funeral director,	Certification:	1 Aural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	Injury ome, farm, str y)	M eet, facto	1 🗆 Ye	s 2 No		ocation (Stre		ber or Rura	Route Number,
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	Sie		30. Name and address of person who company A. De Vice	mpleted cause of death (Iter	n 23a) (Type,	Print)	Shee	100	4	ett.	CO: 10	e Mit	20781
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1.7	0 -30-4	7.0	, 10	77 13	, , (·	1-01-	0/3/

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Titne of Death Month Day **Physician** July 6 2005 12:00 AM Eleanor S. Mitchell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Yrs. Director 78 1927 North Carolina 212-30-5215 17 Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City, Town or Location 10d, Inside City Limits 28a-f show traumatic event, the Medical Exaction round be notified at Clinton 1 XYes 2 No Prince George's Directo Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 20735 3200 Accolade Drive United States or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: Black 3√ Widowed 4 □ Divorced Specify-"natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, IL.A. ODG. 6th Housekeeping Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter R. Knight Sadie E. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Crandell/Sister 3200 Accolade Dr., Clinton, MD 20735 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 7/11/2005 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONJA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (unas a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 Ro 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) Shuf form, no 050862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHERSF HASSAN IMO, 9831 CREENBELT ROAD, SUTTE 103. LANHAMINO 20706

Registrar DHMH 17 Rev 1/200

State

32. Registrar's Sippellure

			- FOI	partment of Health and Mertificate of Death		0.0.	
			1 Decedent's Name (First Middle Last)	eruncale of Dealif	2. Date of Death	g. No2 [] [] 5	3. Time of Death
ı	Physici		Coward Mckenna		July 4,	Day Year 2005	6:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	·
			Manor Care Potomac	Potomac		Montgome	
	Funeral Director		5. Social Security Number 067-22-3929 6. Sex 1 M 2 F 7. Age (In yrs. last birthda of the control	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1	1929 New	lace (State or Foreign try) York
	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10	0d. Inside City Limits
	Maryl f sho	ğ	Md. Montgomery Po	tomac			Yas 2 No
	h the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	itry?
	23a c		10714 Potomac Tennis Lane	20854		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-f show among in luly og søper traumatic evant, the M. dical Examinar must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ♣ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates Korea	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 XNo Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: Wh-	
aryland 21215-0036	2 hou		15, Decedent's Education 16a. De	edent's Usual Occupation	. 1	6b. Kind of Business/Inc	
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and	d be fi	Be	17. Father's Name (First, Middle, Last) James McKenna		e (First, Middle, M		
Ž	should and Men amarke umatic	2		iling Address (Street and Number or Run	r Mahoney al Route Number,		Code)
≥	and 2 ealth ar n 27 is		Janel A. McKenna/Daughter 323	70 Arbor Lake Dr.,	Wilsonvil	le, Oregon	97070
Baltimore,	Pages 1 and of He Inti. If Item		1 Burial 2 Cremation 3 Removal from State	ematory or other place)		Oc. Location - City or To	
alt.	permit. P Departme Importan any Injur		21. Signature of Funeral Service Loense	22. Name and Address of Facility De V			g, Mu.
Ö	Deparent Deparent Important Irreportant Ir		Juni F KAN	2222 Wisconsin Ave			20007
r			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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8760	physic the b	dicai	d. Caffe	g ennor			
×	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	rv
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)			Day Year
ري ص	res that igned by be deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
ord	w require been sig should b				1 🗌 Yes	2 No 3 Proba	ably 4 Unknown
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	ysician: The l is certificate ha director, page					ZNio 1 □ Yes	2□ No
Vita	siciar certif	o Be	25. Was case reterred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		h (Check only onle) nce 6 □Other (Specify	
O	를 를 끌	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how)
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Division of	after de Directe d in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
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	To the within To the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month; L	Day, Year)
. ,	N41		> kuti Votra M.D	D-2027	74	7/3/0	5
(01.		30, Name and address of person who completed cause of death (Item 23a) (Typer Man 1997)	investigation, in my opinion, death occurring the second section $D-2027$ a, Print) $Bacada$	13000	Beth	Kda,
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Careto !		MD:	20817
	Registr	ar	JUL 11 2005 Brown St A				

Bruce Alvin Miller 5-04 PD

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			1 - For State Registrar						Death			leg. No.	200	5 21	200
П	Physici	an	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	th Day	Yea	3. Time	of Deeth
	/Medic	al	Bruce Alvin 4a. Facility Name (If not institution, give				45 0%	T	1	15 "	July 7,			172	9 P M
	Examin	er	7317 Parkway Drive	e South	")		Hano		Location of	of Death			ne Ar		
	Funeral	_	Social Security Number 6. S	ex 7. A	Age (In yrs. I	ast birthday)	If Under		If Under		8. Date of Birth	1		Birthplace (Star	te or Foreign
	Director		212-70-1381	M 2□F	46	Yrs.	Months	Days	Hours	Min.	(Month, Day Aug. 24	, rear)		arylanc	
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
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	th the or 288 e noti	Director	10e. Street and Number	-		110.	10f. Zip	Code			-	l0g. Citiz	en of What	Country?	
	ath wi		506 Lewis Court					217	71			Uni	ted S	tates	
	er de	Funerai	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13. V	Vas Deced f Yes, spec	dent of Hi city Cuba	spanic Orig п, Мехісап	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Ar Black, W	merican Indian hite, etc.	,
936	urs aff	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		-	I □ Yes	2 🔀 No	Specify:				Specify:	White	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show avant, tra Madical Exemirar mant te noillind at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	I	16a. Deced	lent's Usua	al Occupa	ation during most	t of worki		16b. Kin	d of Busine	ss/industry	
2	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4o		life. L	OO NOT us	se retired,)						
	filed v Hygie other t	Co	17. Father's Name (First, Middle, Last)	12	¥	Assist	ant D	istr			ner (First, Middle,		er Con	mpany	
an		To Be	Brooks Davis								ia Balo		umamoj		
Maryland	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address	(Street a			l Route Number		Town, State	, Zip Code)	
	and 2 ealth on 27 I		Sandra L. Holcom	o / Fianc			Lewis			lt. A	iry, Ma	ry1a	nd 21	771	
ore	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐	Removal from Stat	20b. PI	ace of Dispos metery, cren	sition (Nan natory or o	ne of ther place	θ) .			20c. Loc	ation - City	or Town, State	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen		Fre	derick			у	Ju1y 20	05	Fred	erick	, Maryl	and
Ba	Depa Impo any i	l,	21. Signature di Figneral Service Licent	75		8	E. R	idgev	ville	Sta Blvo	uffer F	uner Air	al Hom	mes, P.	A. 21771
i.	۶,		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each	ed the death line.	. Do not ente	er the mod	e of dying	g, such as	cardiac o	r respiratory arr			Approxin Interval E	nate Between
1	Physician -	X A	Immediate Cause (Final disease or condition resulting in death)	a. Lut d Due to (or a	+ Int	Anopa	PP	lat	5 box 1	Voc	1			Onset an	id Death
	/Medical Examiner		resulting in dea(ii)	Due to (or a	is a consequ	ence of):	0	U							
	Arq	er	Sequentially list conditions, if any, leading to immediate cause. Enter Un Jerlym 9	b. — Due to (or a	ıs a consequ	ence of):								-	
	cuted	Examiner	that initiated events	c.	,										
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	is a consequ	ence of):									
∞	icate b physic s the b	dicai		d											
Rox 6	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar	ncy						25	d. Date of o	lalivan	
	death e atte	iciai	in the past 12 months?	1□Live birth 4□Pregnant			Ectopic pri Other (sp					20	Month	Day	Year
J O	at the by th	hys	9 Unknown	9∐ Unknown											
_	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	ontributing to death	but not resu	iting in the ur	iderlying ca	ause give	n in Part I.					to the cause of	
ecords,	w require been si should t	leted									1 L Ye	es 2 🗆	No 3□	Probably 4	Unknown
Hee	0 5 0	ompi									24a. Was a autops	iv	24b. Were prior to death	autopsy finding o completion o	s available cause of
VITal	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical						OC Place	at Danth	(Check only on	2 No	1XY		
	ysician: is certific director.	OB	examiner?	Hospital:	tient 2 🗆 E	ER/Outpatient	3 DO	Othe			1e 5 ☐ Reside	.,	ClOther (Sr	necify) at i	scene
n ot	Attanding Physician: r death. sctor: After this certific by the funeral director.	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of	2	8c. Injury Work	at		8d. Describe ho	w injury	occurred		
<u> </u>	tandi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	717		1729 H	sues	1 🗆 Y	res 2		subject				
DIVISION	after death after death Director:	Certificat	4 ☐ Homicide determined	building,	etc. (<i>Specify</i> ,		fice	, office		2	8f. Location (SI City or Town	i, State)	7317 P	Rural Route Ni	vive-Pos
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	aC	29a. Certifier 1 ☐ Certifying Ph	sician: To the bes	nader	viedge, death	occurred :	at the tim	e, date and	d place, a	nd due to the c	M ause(s) a	nd manner	as stated	
	he Ho in 24 I he Fu pletely	edical	(Check only 2 Medical Exemone)	iner: On the basis and manners	of examinati	on and/or inv	estigation,	in my op	oinion, deat	h occurre	d at the time, d	ate and p	lace, and d	ue to the cause	e(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2/			29c	. License	number		2		-	nth, Day, Year,)
	. 0		I headen MI	King.	مس			OC!	ME			July	8, 2	.005	
	15		30. Name and address of person who o	completed cause of	death (Item	23a) (Type, I		1 Po	nn St	reet	Baltim	ore 1	Martil o	and 212	01
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signati	ure	1.1.	* TCI	יחו טרי	LCCL	Dalli	ore I	тат ута	11U 21Z	OI
	Registr		JUL 1	2 2005		K	Same	1							
DUI	MU 17 Day 1/00	001					1								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan	•	artment of H		nd Mental Hy	/giene	200	21 201
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Do	Day	Year	9. Time of Death
	/Media	cal	Cornel: 4a. Facility Name (If not institution, give		Ma	cka11 4b. City, Town, o	r Location of I	July	6,	2005 County of Death	11:15 P ^M
	Examir	ier	1805 Sixes Roa			,		ederick	40.	Calve	
	Funeral Director		5. Social Security Number 214-30-0403 6. Se	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi	th Year) 193	9. Birth Cou 5 Mar	nplace (State or Foreign untry) y Land
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Mary a-f sho	tor	Maryland Calv	ert	Pri	nce Fre	ederic	k			1 ☐ Yes 2 ☐ No
	h with the 23a or 28a st be not	ai Directo	10e. Street and Number 6689 Mackall	Road		10f. Zip Code	20678		-	izen of What Cou USA	untry?
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinatir ust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Widowed	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 🎇 No	lispanic Origir an, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Amer Black, White Specify: B	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet rival by notified at ance.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired Janitor	during most o d)	f working		ind of Business/li Janito:	•
and 2	d be filed v intal Hygie ed other t event, th	Be	17. Father's Name (First, Middle, Last) Chester	Mack	a11,			Name (First, Middle	, Maiden		1141
Mary	d 2 should th and Me t7 Is mark traumatic	2	19a. Informant's Name/Relationship (7) Denise Hartridg	rpe, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Numb	er, City o	r Town, State, Z	
Baltimore,	ages 1 an ant of Heal it: If item 2 y or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. F	lace of Dispo emetery, crei	sition (Name of matory or other place	ce)	Date 12/2005		ocation - City or T	Town, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licens Placky 4.							•	me ,MD20678
IF S	Physician		23a. Part1. Enter the dilease, or composhock, or heart failure. List only of the timediate Cause (Finat disease or condition	ications that caused the deat ne cause on each tine.	7			rdiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
	cuted nd ransit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						
8760,	icate be executed physician and s the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a conseq	uence of):						
.O. Box 68	aath certif attending for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		2	23d. Date of deliv Month	very Day Year
S, D	uires that the de signed by the		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Record		Completed						24a. Whas auto pent 1 🗆 Yes		24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 No
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	00	Death (Check only			
ou of	Phys r this rat di	tion: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at	28d. describe		3 Other (Speci y occurred	ify)
Division	or A lifter Direction by	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specif	ome, farm, str		.00 20.00	28f. Location	(Street and wn, State)		ral Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier Check only one) Certifying Phy	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) , date and	and manner as	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of pertition	/		29c. Licens	e number	22112	29d. Dat	e signed (Month	. Day, Year)
)) Car	In m.	0	1)(005	1672		7/8/	105
	2		30. Name and address of person who con Joseph John Ba	•		•		D 1 .	1	MD 006	7.0
	Sta	te	31. Date filed (Month, Day, Year)	rth, III, M.D 32. Registras Signa	ture			Frederi	ck,	MD 206	18
	Registr		JUL 0	8 2005 Marcu	1 St.	and	•				

DHMH 17 Rev 1/2001

			State of Maryland / Department State of Maryland / Department State of Maryland / Department Certificate			giene	
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath ZUU	32Tirho of Death 5
	Physicia /Medic		WILLIAM THOMAS MOORE		JULY 1	Day Year 6.2005	7:01 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death		4c. County of Dea	
			CIVISTA MEDICAL CENTER LAPI			CHARLES	
1	Funeral			Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt (Month, Da	rn 9. Bir y, Year) Co	thplace (State or Foreign ountry)
	Director		235-40-6850 78 Yrs. Usual Residence of Decedent		DEC.1	5,1926WES	T VIRGINIA
	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jical Examitter must be multified at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Man a-1 sh filled	ţċ	MARYLAND CHARLES LA PLATA				1 ☐ Yes 2 XNo
	th the	Funeral Director	10e. Street and Number 10f. Zip C	ode		10g. Citizen of What Co	ountry?
	th wil	a	10060 PENNS HILL RD.	20646		U.S.A	
	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Armed Forces? 13. Was Decedent Forces?	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Ame Black, Whi	
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No			Specify:	
21215-0036	hour tural	q pe	3 Widowed 4 □ Divorced Year or Dates: 2x 15. Decedent's Education 16a. Decedent's Usual 0	Occupation	1	16b. Kind of Business	WHITE
7	in 72 ina ina	Completed	(Specify only highest grade completed) (Give kind of work life, DO NOT use	done during most of work	ting	IGD. Kind of Dusiness	industry
712	within liene. r than "	шо	College (1-4or 5+) SAWYER			SAWMILL	
	i Hygi other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	•
ılar	uid be Jentat rked o	To E	JESS WILLIAM MOORE	MARY	LINDA	PLYER	
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Street and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, If we work Examitter must be millihed at once.		BILLY MOORE-SON 10060 PEY			PLATA, MD	20646
altimore,	of He of He iter		20a. Method of Disposition Mill Sturial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or other	er place)	Date	20c. Location · City or	Town, State
<u>Ĕ</u>	Pages ment of ant: If it		'4 □Donation 5 □Other (Specify) ST.MARY'S CE		29-05	NEWPORT,	MARYLAND
Ball	Depart Depart Import eny inj			Address of Facility OND FUNER	AT SEDI	VICE D A	
ш	00 E 6 0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode				
			shock, or heart failure. List only one cause of each line.			rrest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. Ventricular 7qc Due to (or as a consequence of):	hycard	19		Onsot and Doam
r	/Medical Examiner		Due to (or as a consequence of):	/			
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
nt	ted	Examiner	cause. Disease or injury				
H.	and al-tra	xar	that initiated events c				
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	ical E	d				
89	ificate g phy as the	edic	0.				
Вох	eath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	eT		23d. Date of de	livery
	death	icia	in the past 12 months? 1 Vec. 2 No. 4 Pregnant at time of death 5 Other (spec			Month	Day Year
P.O.	that the de ned by the a detached t	hys	9 ☐ Unknown			The same	
	The law requires that the tee has been signed by the page 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	ise given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ord	w requir been si should	ted			1 🗆 1	Yes 2 No 3 P	robably 4 Unknown
ecc	e lawr has be ge 2 sh	ple			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Vital Records,	The ate h page	Completed				rmed7 death?	2 □ No
/ita	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Dea	th (Check only o	ne)	
of	hysi this c	P	1 ☐ Yes 2 ☐ No Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA	was an improved to the first		dence 6 Other (Spe	cify)
п	ding P. h. After i funera	iuoj:	- Addrai 5 Toliding	e. Injury at Work?	28d. Describe h	how injury occurred	
Division	Attending Physician: r death. ector: After this certifica by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be	1 Yes 2 No	20f Lagation //	Street and Number or R	ural Bauta Alumbas
\leq	l or Attenuafter deatl Director: I in by the	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	office	City or Tox		urar noute rumber,
1	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 13-Certifying Physician: To the best of my knowledge, death occurred at	the time, date and place	and due to the	cause(s) and manner as	s stated.
	24 hr 24 hr Fun etely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	n my opinion, death occur	red at the time,	date and place, and due	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me		License number		29d. Date signed (Mont	th, Day, Year)
	->-0		James Harring	D-52919		7/17/0	15
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			-1	
	10		TAMEC T HADDING MD 100 CENTERING	SUITE102 LA	PLATA,MI	D -206//6	
	Sta	te	31. Date filed (Month, Day, Year) 5 2005	······································	- 11/11/11 ji'll	20040	
	Registr	ar	JOL WOLDOWS JOSEPH ST. J.				

		ļ	1 - For State Registrar	Sta	ate of Ma	aryland		artmen			and M	lental Hy	giene Reg. 20	05	24296
	Physic /Medi		1. Decedent's Name (First, Middle Walter Den	nis Nic				1				2. Date of De	103	2005	3. Time of Death
	Examir	ner	4a. Facility Name (If not instituti Washington Co	unty Ho	spital			Н	lager	Location	n		V	anty of Death	
	Funeral Director		5. Social Security Number 504–50–4399 Usual Residence of Decedent	6. Sex 1 🔀 M 2		θ (In yrs. las 61	* * *	If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da Oct 13	, 1941	9. Birthp Coun	lace (State or Foreign try)
	Maryland	tor	PA Fr	anklin			Town or Lo							1	0d. Inside City Limits 1 XYes 2 No
	h with the 38 or 28¢	Funeral Director	10e. Street and Number 154 S. Pric	e Avenu	1e			10f. Zip	Code 172	268			10g. Citizen	of What Coun	try?
920	72 hours after death with the Maryland netural', or Items 23e or 28e-f show Jical Eve Jil ver invet be truithed at	þ	11. Marital Status 1 Never Married 2 Mar Mar 3 Widowed 4 Divorce	1A	as Decedent med Forces? TYes 2 1 Yes, Give ear or Dates:			Was Deced if Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	Race - Americ Black, White, ecify: Whi	
Maryland 21215-0036	within ane. than "	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)				(Give life.	dent's Usua kind of wor DO NOT us dier	rk done d se retired,	ation Juring mos.)	t of worki	ng		Govern	·
yland	should be filed and Mental Hygid is marked other aumatic event, II	To Be (17. Father's Name (First, Middle Walter Nic									(First, Middle, ret Cla		name)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relation Patricia Nick		wife		1 54	S. F	rice			nesbor	-		Code)
Baltimore,	of of the state of		20a. Method of Disposition 1 □ Burial 2√□ Cremation 4 □ Donation 5 □ Other (i 3 ∏ Remov 'Specify)	al from State	сеп	netery, cirer er lan d	nsition (Nam natory or of Valley	ther place 7 Cre n	n.	Ju1	14 2005	Wayn	on - City or To esboro	, PA
Balt	permit. Pag Department Important: I any injury o		21. Signature Juneral Service	e Licensee	mo	oorl_	. 22					ve-Powe aynesbo			Home, Inc
	/Medical Examiner	Examiner	23a. Part1. Enfer the disease, shock of heart failure. List immediate Gause (Final disease or condition resulting in death) Sequentially list conditions, any lacent immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a b	Due to (or as	a conseque	nce of);	er the mode	e of dying	g, such as	cardiac	or respiratory and	olit	1	Approximate Interval Between Onset and Death Juer August
8760,	icate be executed physician and the burial-transit	dical Ex	resulting in death) Last	d	Due to (or as	a conseque	nce of):	ed		Ju	∞ ≟	9 (20m	con a	2 years
O. Box 6	at the death certific by the attending p tached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 (4 (yes, outcome Live birth Pregnant at Unknown	2 Fetal de	eath 3[Ectopic pre Other (spe			,		23d.	Date of delive Month	ry Day Year
rds, P	es this	by	Part II. Other significant condit	tions contribut	ing to death b	ut not resulti	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did to	/		e cause of death?
Vital Records,	The law ate has b page 2 sl	Completed												prior to con death?	osy findings available inpletion of cause of
of	Attending Physicien: T r death. ector: After this certificat by the funeral director, pa	ertification; To Be		Hospita 28a ing tigation	al: Inpatie a. Date of Inju (Month, Da)	ry 2	NOutpatier 8b. Time of Injury		Bc. Injury Work	r: 4□ Nu	rsing Hor	(Check only one 5 ☐ Resident	dence 6 🗌)
Division		Certific	3 Suicide 6 Could 4 Homicide deter	d not be mined 286	e. Place of Inj building, et	ury - At hom c. (Specify)	e, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		ımber or Rurai	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	one)	il Examiner: O	: To the best of the basis of and manner sta	f examination	edge, death n and/or in	occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the dead at the time, d	cause(s) and date and pla	manner as sta	ated. the cause(s)
)	To t To t	2	29b. Signature and title of certif			1	MI	290.	License	number 6 L	+ M.	3	29d. Date sig	gred (Month, L	3 . 2005
H-1	15+1		30. Name and address of perso	-1 or	ed cause of d	eath (Item 2	3a) (Type,	Print)	30		DPA	LCT	1.1	Tago	stown
	Sta Registr		31. Date filed (Month, Day, Yea JUL 1	5 2005		ar's Signatur	9. D	oute	,				l	J	10132174

			For			d / Depa	artment of H	lealth a	nd Mental Hy	giene	•	
			1 - State Registrar			Ce	rtificate of	Death			005	24297
	Physici	an	Decedent's Name (First, Middle, Last	st)					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		Luther Lee Nut						July	10,2		6:35p M
	Examir	ner	4a. Facility Name (If not institution, give				4b. City, Town, o		f Death		County of Death	
			Frederick Memo 5. Social Security Number 6. S			ast birthday)	Freder:		24 Hrs. R. Date of Bi		Frederic	
	Funeral Director			X M 2□F 7. A	87	Yrs.	Months Days	Hours	Min. B. Date of Bi	6, 19	COU	place (State or Foreign ntry) Virginia
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary Feb	ţō	Maryland Frederi	ck		Br	unswick					1 XYes 2 □ No
	r 28a	lrec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	th wit	ai D	518 Souder Road				217	16		Unit	ted Stat	es
	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-1 ehow Tha Majical Evantiner must be rodified at	Funeral Director	11. Marital Status	12. Was Decedent Amjed Forces	7		Was Decedent of H	lispanic Orig	jin? (Specify Yes or No Puerto Rican, etc.)	o- 1	4. Race - Ameri Black, White,	
98	or it	y Fu	1 Never Married 2 Married	1 🖟 Yes Cive	No WOT.	La	1 ☐ Yes 2 No		, , , , , , , , , , , , , , , , , , , ,	1		ite
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	War .	11						
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16b. Kin	d of Business/Ir	ndustry
12	withii ene. than	шć	Elementary/Secondary (0-12)	College (1-4or	5+)	Carm		<i>D)</i>		F	Railroad	
d 2	il Hygiene. other thai		17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle			
<u>a</u>	should be nd Mental marked o matic eve	To Be	Parker P. Nutter					Marga	ret E. Eve	rsole	2	
Maryland 21215-0036	the party of the p		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	an <i>d Number</i>	r or Rural Route Numb	er, City or	Town, State, Zij	Code)
	1 and 2 Health a tem 27 Is	1	Lauretta Nutter	/ Wife		518	Souder R	d., Br	unswick, M	D 217	716	
Baltimore,	ges 1 a it of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Pf	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Loc	cation - City or T	own, State
Ĕ	Pag ment ant: I ury o		`4 □ Donation 5 □ Other (Specify		Fre		Cremato		/12/2005			Maryland
3alt	permit. Pages Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licen	see /					Stauffer			
	₫ O E # Ø		1 owney	Stany	pur				e Ave., Br		ick, MD	21/16
٦.			23a Part1 Enter the disease, ir com- shock, or heart failure List only	olications that cause one cause on each l	the death line.	. Do not ent	er the mode of dyir	ng, such as c	cardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a			1)ne	run	onla			Oliser and Death
	/Medical Examiner		Tostiling in doubly	Due to (or as	s a consequ	ience of):						
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	s a consequ	ence of):	<u> </u>					
	uted I Insit	Ë	cause. Enter Underlying Cause (Disease or injury that initiated events		,							
Ć.	be executed sicien and burial-transit	Examiner	resulting in death) Last	Due to (or as	s a consequ	ience of);		· · · · · · · · · · · · · · · · · · ·				
760,	# × 9	cal		d								
68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Medi	15.55441.5									14.5
Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		2	3d. Date of deliv	,
Э. П	e dea he at hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown			Other (specify)				Month	Day Year
P.0	that the de ned by the a detached t	Phy	9 Unknown			Min - i - Al-	4-1-1	a in Bank	02- Did			
JS,	ires the signer	by	Part II. Other significant conditions of	ontributing to death t	out not resu	iting in the ui	nderlying cause giv	en in Part I.	230. 010			he cause of death?
9	v requir been s should	Completed									JNO 3 110L	Dabiy 4 DOTKHOWN
3ec	e law has l	mpi							24a. Was	an psy ormed?	24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
									1 ☐ Yes	247 No		2 🗆 No
₹	Physician: T this certificateral director, pa	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati		ER/Outpatien	Oth	or.	of Death (Check only			
	y Phys	n; To	27. Manner of Death	28a. Date of Inju	ury	28b. Time of	28c. Injur	y at	sing Home 5 Resi 28d. Describe			y)
<u>0</u>	Attending F r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	Wor M 1 □	k? Yes 2.∏N	lo			
Division	or Attendated after deatl Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At hor		eet, factory, office		28f. Location (City or To		Number or Run	al Route Number,
	tal or A	Certification;		Daliding, e	ic. (Specify,				City of 70	wii, State)		
	To the Hospital or Attending Phwiling 4 hours after death. To the Funeral Director. After the completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best liner: On the basis o and manner st	ot examinati	vledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, death	place, and due to the n occurred at the time,	cause(s) a date and p	and manner as s place, and due to	tated. o the cause(s)
	To the To the Comp	ž	29b. Signature and tive of certifier	0	_		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
)			Smil	Some		200	D :	83	71	7-	11-05	
8	+1		30: Name and address of person who	completed cause of c	death (Item	23a) (Type,	3	1 Hoz	ise Av	eF.	redenie	LMD
	Sta Registr		31. Date filed (Month, Day, Year)	2 2005 Regist	r's Signat	ure K	fred.			1	2	1701

			1 - For Stete Registrer	State of I	Maryland		artmen rtificat			nd M	lental Hyg	iene .g. No2 N 1) [01.	200
	Physic		Decedent's Name (First, Middle, L Lee A.	ast)	Olso						2. Date of Deat Month	h Day	Year	3. Time	Death P M
	/Medi Exami		4a. Facility Name (If not institution, g. Woodside Center	ive street and number	er)				Location of		_July	9, 2005 4c. County	of Death	9:18	F
	Funeral Director		319-05- 7763	Sex 7. 1 □ M 2 1 F	Age (In yrs. Ia: 88		If Under Months		If Under 2		8. Date of Birth (Month, Day, Jan. 13			ace (State try)	or Foreign
	the Maryland 28a-f show	2	Usual Residence of Decedent 10a. State 10b. County			Town or Lo							10	Od. Inside C	
	or 28a-f	Directo	Maryland Montgo	omery	51	lver	Sprin 10f. Zip				10	g. Citizen of W	hat Count		2 🔼 No
	ath w	<u>ra</u>	9618 Lorain Ave	nue				209	01				USA		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Expirit at must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🌣 Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? XINo	li li	Vas Deced Yes, spec	rty Cuban	panic Origi , Mexican, Specify:	n? (Spe Puerto f	cify Yes or No- Rican, etc.)	Black	- America , White, e Whit	etc.	
21215-0036	within 72 hours iene. than "natural", hs Medical Exa	Completed	15. Decedent's 8 (Specify only highest gi	ducation ade completed) College (1-4c		life. E	kind of wor OO NOT us	k doné du e retired)	ion uring most o	of workin	ng 1	6b. Kind of Bus		,	
Maryland 2	be filed withintal Hygiene. ad othar thanevant, the M	Be	17. Father's Name (First, Middle, Las Daniel Hawryluk	t)		Seci	retar				(First, Middle, M	laiden Sumame		cation	ns
3	should be nd Mental markad o	2									Bastte:				
	is 1 and 2 sho of Health and itam 27 is my other traums		19a. Informant's Name/Relationship Charles Olson/ S			9618	Lora	in A			Route Number, 1ver Spr				
Baltimore,	~ ~ ~		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		te cerr	ce of Dispos netery, crem opolita	atory or ot	her place)			11.	oc. Location - 0 .exandr:	•		nia
Ball	permit. Page Department of Important: If any injury of any injury of		21. Signature of Funeral Service Lice	nsee Myll		22. F r 8	Name and ancis Uni	Address J. (of Facility Collin Lty Bl	ns F Lvd,	uneral I W, Silv	Home Ind	ing,	MD 20	0901
	Physician	i d	23a. Parti Shter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	One cause on each	ed the death. line. dial II			of dying,	such as ca	rdiac or	respiratory arre	st,		Approximat Interval Bet Onset and I Sudder	ween Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequer	nce of):									
	cuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of injury that initiated events	b. Due to (or a	s a consequer	nce of):									
68760,	ficate be executed physician and ts the burial-transit	edical Ex	resulting in death) Last	Due to (or a	s a consequer	nce of):									
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal de at time of deat	eath 3 🗆 8	Ectopic pre Other (spe					23d. Date Mont			/ear
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of Hypertension, Hy	ontributing to death	but not resultir i.sm	ng in the und	derlying car	ıse given	in Part I.		Ti .	cco use contrib			
		Completed								_	24a. Was an autopsy performe	d? pri	ore autops or to comp ath? Yes 2	sy findings a pletion of ca	available ause of
Viita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							Death ((Check only one)				
ot	Physical this call dire	၉	1 ☐ Yes 2x No	Hospital: 1 ☐ Inpat		/Outpatient		-	+ W INUISI	ng Home	e 5 🗆 Residen	ce 6 Other	(Specify)		
Division of	Attanding Physician: r death. sctor: After this certifice by the funeral director. p	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			b. Time of Injury	М		t s 2⊡No		ld. Describe how	injury occurred			
<u> </u>	ntal or Attanours after death ral Diractor:		4 Homicide determined	building, e	etc. (Specify)						f. Location (Stre City or Town,	State)			be <i>r</i> ,
:	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	ledical	one)	ysician: To the besi niner: On the basis and manner s	ot examination	dge, death o and/or inve	occurred at estigation, in	the time, n my opin	date and p ion, death o	lace, an	d due to the cau at the time, date	se(s) and mann a and place, and	er as stated due to the	ed. 1e cause(s)	
1	Viith	M	29b. Signature and title of certifier	ma	/		29c. I	D323			29d Ju1	Date signed (in y 11,	Month, Da		
	_		30. Name and address of person who Suresh K. Gupta	completed cause of M.D. 9	death (Item 23 801 Geo	a) (Type, Pr	int) Avenu	ıe, #	220,	Silv	ver Spri	ng, MD	2090	2	
	Sta Registra		31. Date filed (Month, Day, Year)		rar's Signature	Some	K								

			1 - State Registrar	State of Marylan		artment <i>rtificate</i>				_	giene Reg. No:	005	24299
			1. Decedent's Name (First, Middle, Last)					-		2. Date of De			3. Time of Death
	Physici		GRADY HAMPTON OLI	DHAM						Month July	Day 8	2005^{Year}	
	/Medi Examir		4a. Facility Name (If not institution, give str			4h City T	Own or	Location o	of Death	July		ounty of Deal	J.J. I
1	Examili	iei		cot and trainbot,					JI DBalli			•	
	Eunaval		5708 31st. Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. I	last hirthday)	Hyat If Under 1		If Under 2	24 Hrs.	9 Date of Bird			eorge's
	Funeral Director			^{M 2□ F} 75	Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da Dec. 7,	y, Year)	9. Bin	thplace (State or Foreign puntry)
L.,			Usual Residence of Decedent	13						Dec. 7,	1929	VII	ginia
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation			****				10d. Inside City Limits
	Man	ŏ	MD Prince Geo	orga's Hys	ittsví	110							tv∑Yes 2 No
	1588 2888	e C	10e. Street and Number	orge s liye	ILLSVI.	10f. Zip C	Codo				10a Citiza	n ={ \4/b = 1 O =	
	with	0				207						n of What Co	ountry :
	eath	Funeral Director	5708 31st. Avenue	. Was Decedent Ever in U.	C 12.1				-:-0 (0	* M		S.A.	
	Item	'n	1 Never Married 2 Married	Armed Forces	3.	f Yes, specif	fy Cuban	n, Mexican	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)	. 14	. Race - Ame Black, White	
36	rs af	by	3 X Widowed 4 □ Divorced	1X Yes 2 No 195 If Yes, Give Year or Dates: 195	2	1 □ Yes 2)	No No	Specify:			s	pecify:	
21215-0036	hou tura	g	15. Decedent's Educa			dontin Havel	0	*:			1.71		nite
15	n 72	Completed	(Specify only highest grade of	completed)	(Give	dent's Usual kind of work DO NOT use	done du	tion uring most	of worki	ng	16b. Kind	of Business/	Industry
12	withi ene. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		Mech					D C	Co Co	overnment
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Wedical Eventher must be routiled at		17. Father's Name (First, Middle, Last)		Auto	Mech			do Nama				Jvermment
ano	should be fand Mental Fand Mental Fandswed of	Be					-			(First, Middle,			
Ž	Mould Mark Mark	2	Jasper Grady Oldhar							auline			
Maryland	12 st and rand		19a. Informant's Name/Relationship (Type							l Route Numbe			Zip Code)
	and 2 lealth ar m 27 is her trau		Barbara L. Estes, I						_	e Park,	Mary	land	20740
0.0	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If Item 27 is marked other than "natural; or Items 23s or 28s-f show or other traumatic event, Its Medical Erapuns must be notified at		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ren	noval from State	ace of Dispo- emetery, cren	sition (Name natory or oth	e of er place	,		ate	20c. Loca	tion - City or	Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; if Item 27 is any injury or other tra ance.		' 4 ☐ Donation 5 ☐ Other (Specify)		t Line	oln Ce	emete	ry 0	7/13	3/05 1	Brent	wood,	Maryland
at	permit. Depart Import any inj		21. Signature of Funeral Service Dicensee	0,	1 22	. Name and	Address	of Facility	Gas	ch's Fu	nera1	Home,	, P.A.
m	89 = 9		N Constan	e Mase	47	739 Ba	1tin	nore .	Aven	ue, Hya	ttsvi	11e, N	Maryland
П			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death	. Do not ente	er the mode	of dying,	such as c	cardiac o	r respiratory ar	rest,		Approximate
W	Physician	S: 0	Immediate Cause (Final disease or condition							41			Interval Between
			disease of condition		111		11	401		1 10			Onset and Death
	/Medical	1111	resulting in death)	Due to (or as a consequ	ence of):	ry	Ar	ter	y	Dise	use	-	5 years
	Examiner		resulting in death)	Due to (or as a consequ	ence of):	ry	Ar	ter	Y	Dise	use		5 years
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c c	Examiner	Examiner	resulting in death)		ence of):	ry	Ar	ter	Y	Di se	eu se		S years
760,	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):	ry	Ar	ter	Y	Di se	eu se		S ugars
68760,	Examiner	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):	ry ,	Ar	ter	7	Di se	eu se		5 years
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		30). Name and address of person	who completed cause	of death (Item :	23a) (Type,	Print) FO	KITH	HIXDOF	dT 1	1117	
		V	TAMPES W.	who completed cause of GAACS 2 2005		SAL	15BUR	y de	7 2/8	01-		-4
	State	3	1. Date filed (Month, Day, Year)	32. Reg	trar's Signatu	ıre						
Regi	strar		JUL 1	2 2005	and a	K	had.					

			1 - For State Registrar	State of Maryla	-		of Health ar of Death	nd Mental	Hygien	2005	24301
	Physici		1. Decedent's Name (First, Middle, Las		ttre	anc		2. Date of Month		ay Year 7 2001	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give 3010 Ellicott Ro	street and number)		4b. City, Tov	wm, or Location of I	Death /	1	c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sec 579. 34. 0777		rs. last birthday) 7 Yrs.	If Under 1 Y	ear If Under 24	Min. 8. Date of (Month) Apri	f Birth Day, Year 1 23,		hplace (State or Foreign untry) York
	h the Maryland r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10e. Street and Number		City, Town or Lo		de		10g. C	citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, I'm Medical Ever in at mast but inclined at	by Funerai	3010 Ellicott Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ②No If Yes, Give Year or Dates:		207 Was Decedent f Yes, specify 1 ☐ Yes 2 ☑ dent's Usual O	t of Hispanic Origin Cuban, Mexican, F No Specify:	n? (Specify Yes o Puerto Rican, etc	r No-	J. S. A. 14. Race - Ame Black, White Specify: White Kind of Business/	e, etc. nite
21215-0036	id within 72 giene. er than "na'	Completed	(Specify only highest grad		(Give	kind of work d DO NOT use n nemaker	lone during most o etired)	of working		Oomestic	
Maryland	2 should be filed within nand Mental Hygiene. 7 is marked other than "raumatic event, trans.	To Be (17. Father's Name (First, Middle, Last) Joseph Restivo	Pantalone	40, 14, 11	A.I. (6)	Carme		lragna	L	To Code)
Baltimore, Mai	0 0 A		19a. Informant's Name/Relationship (7. Edward M. Quattr 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	one/Son 20th Removal from State	9619 c. Place of Dispo cemetery, crer	Corone sition (Name on natory or other	treet and Number of t Court, of r place) Ceme. 07	Laurel,	Mary 20c. I		723 Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licent	eaut	H] 1]	NES-RI 800 Ne				NC. er Sprin	ng, MD 20904
8760,	Physician and was priced by some and physician and physician and physician and the physician and physician are provided by the physician and physician are provided by the physician are p	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or beart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons	sequence of):	ance		rdiac or respirato	ny arrest,		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregn Other (specif				23d. Date of deli Month	very Day Year
rds, P	w requires that s been signed b should be deta	by	Part II. Dther significant conditions or	entributing to death but not	resulting in the u	nderlying caus	e given in Part I.				the cause of death?
Il Records,		Completed						8	Was an autopsy performed?	death?	topsy findings available completion of cause of 2 \(\sum \) No
n of Vital	ding Physician: Th. h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Ponatural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury		Othor		Residence	6 Other (Specury occurred	cify)
Division	or Atten after deal Director: In by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	M eet, factory, of	1 ☐ Yes 2 ☐ No	28f. Locati	on (Street a Town, Star	and Number or Ru te)	ral Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edicai (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the	he time, date and p my opinion, death	place, and due to occurred at the ti	the cause(: me, date ar	s) and manner as nd place, and due	stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and affe of certifier	rlid		1	cense number		29d. D	ate signed (Month	0, Day, Year)
	5		30. Name and address of person who co	ompleted cause of death (I	1 7	Print)	, Weint	sera Buil	ding	Baltimor	e Maryland
	Sta Registi	- 4	31. Date filed (Month, Day, Year) JUL 12 200	2. Registrar's Sig		te	J	7	7		3

Year

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Mor

Registrar's Signature

2005

			1 - State Registrer 1. Decedent's Name (First, Middle,		d / Department of Health and I Certificate of Death	Mental Hygi	iene g. NE 005 24303
	Physic /Med Exami	ical	Audrey Ri 4a. Facility Name (If not institution,	ISSUM	4b. City, Town, or Location of Death	2. Date of Death Month	Pay Year 1913 M
	Funeral Director	H	University of Mar 5. Social Security Number 217-36-0885	Vland Medical Cent Slsex 7. Age (In yrs. Iz 1 □ M 2 XF 83	to Baltimore	8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreig Country) MARYLAND
	r 28e-1 show	tor	Usual Residence of Decedent 10a. State 10b. County MD CAROL		Town or Location RIDGELY		10d. Inside City Limits 1 ☐ Yes XXNo
	ath with the 23e or 28e	ral Director	10e. Street and Number 11259 CENTRAL	AVE.	10f. Zip Code 21660	10	lg. Citizen of What Country?
9600	after de or Items	d by Funeral	11. Marital Status 1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? d 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
1215-(n 72	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) LINE WORKER	ing	6b. Kind of Business/Industry
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, the Mental the Men	To Be Co	17. Father's Name (First, Middle, La OLIVER RUSSUM		18. Mother's Nam	e (First, Middle, Mi E STARKE)	
	tem 27		19a. Informant's Name/Relationship LISA L. ADKINS/I 20a. Method of Disposition	PER. REP.	19b. Mailing Address (Street and Number or Rur 613 WATSON RD. CENTRE ce of Disposition (Name of metery, crematory or other place)	VILLE, MI	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		1X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	ST.	JOSEPH'S CEM. 7/16 22. Name and Address of Facility FELLOWS, HELFENBEIN	/2005 & NEWNAN	CORDOVA, MD 4 FUNERAL HOME PA
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death. Ity one cause on each line. a	Do not enter the mode of dying, such as cardiac of the state of the st	CASIUN. N	11) / [60]
8760,	ate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, loading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			70 y & ays
O. Box 6	t the death certific by the attending p ached for use as	Physiclan/Med	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 □Ectopic pregnancy	TV.	23d. Date of delivery Month Day Year
ords, P.	w requires tha been signed should be det	by	Peripheral Vas	1 .	ng in the underlying cause given in Part I.	23e. Did tobad	coo use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,		Completed	Congestive Hea Hypertension	rt Failure		24a. Was an autopsy performe	
of Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)				e 6 ⊡Other (Specify)
Division	ending eath. or: After he fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	on be 28e. Place of Injury - At home	M 1 Yes 2 No	8d. Describe how	injury occurred at and Number or Rural Route Number.
Di	spitel or ours afte nerel Dir filled in	edical Certi	29a. Certifier 1 Certifying F	building, etc. (Specify) Physician: To the best of my knowle	adde death occurred at the time date and place	City or Town, S	State)
	To the Hos within 24 h To the Fur completely	Medi	29b. Signature and title of certifier	and manner stated.	a and/or investigation, in my opinion, death occurre	d at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)
			30. Name and address person who	M.D.	AU4176435 X 167		uly 8 2005
	Star Begistr	te	Zi Rong Xu, M.D. 31. Date filed Chorth, Day Year 1		eene Street Baltimore	, MD a	21201

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent Name (First, Middle, Last) 2. Date of Death Day Year BF Month 8:45am, **Physician** 9. 2005 Julv /Medical give street and number) Street 4c. County of Death 4b. City, Town, or Location of Death Examiner Clear Washington Spring, | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 19,1919 7. Age (In yrs. last birthday) 85 yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐XF 212-80-4695 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State orient: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exeminar must be notified at MD Washington Clear Spring 17 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21722 35 N. Mill St. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Specify: White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) residence and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be fi William Russell Wiles Peges 1 and 2 should by ment of Heelth and Menta ent: If item 27 Is marked Fannie F. Hull 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Gladhill 12408 Houck Ave. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition July ™2, tX Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, MD permit. Pege Depertment c Importent: If any injury or Paul Cemetery 2005 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Physician/Medicai the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 □ Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 TYes completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funerel C Hospitel Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 0022043 person_v GERSTOWN HM 3H-4 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			1- For State of Marylan		artment of He			ene g. No 2 0 0 5	21.205
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		Bradley Albert Rogers, Jr.				July 9,		8:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County of Dea	
	Funeral		Manor Care Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)		If Under 24 Hrs.	8. Date of Birth	Montgome 9. Bir	thplace (State or Foreign buntry)
	Funeral Director		163-07-8434 ^{1፟፟፟፟∭ M 2□ F} 90	Yrs.	Months Days	Hours Min.	(Month, Day, April 1	3,1915 Buf	falo, N.Y.
	pus *		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Maryii f sho	tor		lockvi1					1≹Yes 2□No
	r 28e	Director	10e. Street and Number	.OCKVII	10f. Zip Code		10	g. Citizen of What Co	ountry?
	th wit 23a o ust be	alD	10401 Grosvenor Place # 1618		20852			U.S.A.	
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 194	s. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, e, etc.
39	urs aft	by F	1 Never Married 2 Married 1 Never Married 2 Narried 2 Na		1 ☐ Yes 2 █ No	Specify:		Specify: Wh	nite
200	filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23e or 28e-f show ant, Ite Medical Examinet must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	on ring most of work	ing 1	6b. Kind of Business	/Industry
2	vithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done dur DO NOT use retired)			T *	
5 0	filled v Hygie other t	Co	17. Father's Name (First, Middle, Last)	ועם		nager 8. Mother's Nam	e (First, Middle, M	Liquor Naiden Surname)	
an	lid be lental ked o ic eve	To Be	Bradley A. Rogers				McElvain		
ary	shou and N is man		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and	d Number or Run	al Route Number,	City or Town, State, I	Zip Code)
∑ ~`	and in 27 in		Patricia Rogers / Wife		Grosvenor				
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brain injury or other traumatic event, It at Medical Examinar must be notified at once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	emetery, crei	natory or other place)			Oc. Location - City or	
Ħ	nit. Pa artmen ortant injury		*4 □ Donation 5 □ Other (Specify) MT 21. Signature of Fureral Service Licensee	Comfor	t Cremator	cy July	11,2005	Alexandria	ı, Va.
Ba	Dep Imp		William R. Bear		130 Wiscon				
			23a. Part1. Enter the diseal e, or complications that clus of the deat shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	sclen	offe A	cent (disease	.,	Onset and Death
	/Medical Examiner		Due to (or as a conseq		mest				
	1 3	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of):	10000				
	cuted ad ransit	Examiner	that initiated events C.	xyss.					
90,	i be executed sician and burial-transit		resulting in death) Last Due to for as a conseq	uence of): VEVW					
38760,	ate thys	dlcal	d	Je vv				=	
×	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		De			23d. Date of de	ivery
. B	ed for	Physiclan/Me	in the past 12 months? 1 Ves 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
O. O.	res that the de signed by the a be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not res	ulting in the u	ndarlvina cause aven	in Part I	23e Did tob	acco use contribute to	the cause of death?
Records,	uires t signe Id be (d by	Chamic Obstructure	กูปโ	money <	Freen			obably 4 Unknown
00	w require s been sign should b	lete	Consolvine Hagus	Low	Ine)		24a. Was an	24b. Were au	itopsy findings available
Re	The law te has bage 2 :	Completed	O CENE hom Marguelle	x 0 (Heiden		autopsy perform	ed? death?	completion of cause of
Viital	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?		2	6. Place of Deat	h (Check only one		
	Physician: The la r this certificate has ral director, page 2	으	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier		4 Nursing Ho	me 5 Resider	nce 6 Other (Spe	cify)
O	ttending F death. tor: After the funera	tlon	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work?	s 2 No	20d. Describe not	winding occurred	
Division of	Atter er dea rector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
ō	ital or irs afte rel Dii								
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	wledge, deat tion and/or in	h occurred at the time, vestigation, in my opin	date and place, ion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	ro the vithin 2 ro the comple	Med	29b. Signature and file of certifier		29c. License n	umber	29	d. Date signed (Mont	h, Day, Year)
	10		1 Hay reday		Do	3691		July 9	9.2005.
	(-		30. Name and address of erson who completed cause of death (Item	23a) (Type,	Print)	2001-	Rha 1	Leede	NO 28 17
	-01		31. Date filed (Month, Day Year) 32. Registrar's Signa	ture -	1) 20000	7	J.O., 1	JULIVE JULI	,
	Sta Registr		JUL 12 2005 Kuran A	1 Sp	ales?				

			For	State	of Marylai					lental Hy	giene		
			1 - State Registrar			Cei	rtificate (of Deat	h		Reg. No	200	24306
Н	Physici	an	Decedent's Name (First, Middle, DILLT TD		ROTHCH	IT T D				2. Date of Dea	Da	y 2005 Year	5: Time of beath U
	/Medic		PHILIP 4a. Facility Name (If not institution.	LEON		TT TT	4b. City, Tov	m or l poetic	of Dooth	JÜLY		. County of De	10:50 A M
	Examin	er	3522 FITZHUGH L		unioer)		į i	R SPR			40	·	GOMERY
	Funeral	-		S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Unc	ler 24 Hrs.	8. Date of Birt	h	9.8	irtholace (State or Foreign
	Director		578-32-3760	1 X M 2□ F		84 Yrs.	Months Da	ays Hour	s Min.	OCT . I	4^{Year}	1920 NE	EW YORK
	P		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	antion						104 1-14-05-11-14
	shor	'n	·	OMEDI/									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	MARY LAND MONTG 10e. Street and Number	OMERY		SILVER	10f. Zip Co				10g Cit	izen of What (
	with Sa or		3522 FITZHUG	H LANE				906					ES OF AMERICA
	ms 2;	Funeral	11. Marital Status	12. Was Dec	cedent Ever in t	J.S. 13.	Was Decedent	of Hispanic	Origin? (Sp	ecify Yes or No-		14. Race - An	nerican Indian,
ဖွ	or Ite		1 ☐ Never Married 2 🛣 Marrie		_2□No AR	MY	f Yes, specify 1 □ Yes 2 🔀			Hican, etc.)		Black, Wh	
21215-0036	within 72 hours after death with the Maryland ane. than "naturaf", or Items 23a or 28a-f show 's Madral Examber must be notified at	d by	3 Widowed 4 Divorced	Year or I	Dates: 1944	-46						Specify: WF	
<u>.</u>	"nat	Completed	15. Decedent's (Specify only highest)	(Give	dent's Usual O kind of work d DO NOT use re	one durina m	ost of work	ing		ind of Busines TEDMAT	s/Industry REVENUE
7	withii ene. than	duic	Elementary/Secondary (0-12)	College 4	(1-4or 5+)	-	RNMENT	,	TVE		TIV	SERV	
	Hygie other	a)	17. Father's Name (First, Middle, La	ast)						e (First, Middle,	Maiden		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 23a or 28a-f show aumatic event, If a Mudical Examiner must be notified at	To B	ABRAHAM ROT	HCHILD					ROSE	LEVINE			
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationshi							al Route Numbe			
	and ealth m 27		MIRIAM G. ROTHC	HILD - M						LVER SP			
ore	Pages 1		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 XRemoval from	State	Place of Dispo cemetery, crer	natory or other	place)	1	Date		ocation - City o	
altimore,	t. Partmen		`4 □Donation 5 □Other (Spe		ARL	INGTON					_		VIRGINIA
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury compet traumatic elege.		21. Signature of Funeral Service Li	eensee		11	ANZANSK 170 ROC	Y≕GÖLÎ KVILLE	SBERG PIKE	MEMORIA , ROCKV	L CI	HAPELS, E, MD	INC. 20852
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the dea	th. Do not ent	er the mode of	dying, such	as cardiac	or respiratory are	rest,		Approximate Interval Between
k 1	Pnysician		Immediate Cause (Final disease or condition	a ACU	TE MYOC	ARDIAL	INFARC	TION					Onset and Death IMMEDIATE
	/Medical Examiner		resulting in death)		(or as a conse								
	220	er	Sequentially list conditions,	bCOR	ONARY H	EART D	ISEASE						11 YEARS
	nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010	(01 43 4 001133	4001100 01).							
Ć,	execu n and ial-tra	Examln	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):							
8760,	icate be executed physician and s the burial-transit	dlcal		d									
9		Jedi	IS SEMALE.	1									
. Box	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregn birth 2 Teta		Ectopic pregn	апсу				23d. Date of de	,
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<u> </u>	The law requires that the de tte has been signed by the a page 2 should be detached t	Phy	Part II. Other significant condition	s contributing to	death but not re:	sulting in the u	nderlving caus	a given in Pa	rt I.	23e. Did to	bacco u	ise contribute	to the cause of death?
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CO	w requ	lete	ATRIAL FIBRIL	LATION						24a. Was a		24b. Were a	autopsy findings available
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ta		a)	25. Was case referred to medical					26. Pla	ice of Deat	1 ☐ Yes]	s 210 No
>	- S - D	To B	examiner? 1 🎇 Yes 2 🗌 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	Other: 4 🗆	Nursing Ho	me 5 K Resid	ence	6 ☐ Other (Sp.	ecify)
0	ding Pt h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c.	njury at Work?		28d. Describe h			
<u>S</u>	Attending or death.	cati	2 Accident investiga 3 Suicide 6 Could no	ition				1 ☐ Yes 2	- 1				
Division of Vital	F a F L	ertification:	4 Homicide determin	289. Plac	e of Injury - At h ding, etc. (Speci	iome, farm, str <i>fy)</i>	eet, factory, off	ice		281. Location (S. City or Tow			Rural Route Number,
_	spital ours a	0	29a. Certifier 1X Certifying	Physician: To th	e best of my kn	owledge, death	1 occurred at th	e time, date	and place	and due to the c	ause/s)	and manner a	s stated
	To the Hospital c within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medicel E	xeminer: On the t	basis of examination	ation and/or inv	estigation, in r	ny opinion, d	leath occur	red at the time, d	date and	place, and du	e to the cause(s)
	To th withir To th comp	Ň	29b. Signature and title of certifier		10.		29c. Lic	ense numbe	r	2	29d. Dat	e signed (Mon	oth, Day, Year)
	12		> Am a	ww	(my)			D24543	3		JULY	8, 20	05
	1-		30. Name and address of person w JAMES A. ROSSI,					BI.VD.	, STI	VER SPR	ING	MD 2	0906
	Sta	te	31. Date filed (Month, Day, Year)						, 011	DIK		2	
	Registr		JUL 12	2005	Buch K	ature April	ME						

Richard Robert Raezer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04575 State of Maryland / Department of Health and Mental Hygiene MUN Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Richard Robert Raezer, Jr. July 2005 1209 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 40 Lively Lane Elkton Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y AUG 1, 1 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 💢 M 2 🗆 F Yrs. 163-28-7906 Pennsylvania Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21921 United States Items 23a 40 Lively Lane death 12. Was Decedent Ever in U.S. Amed Forces? 1954-1 Xi Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian e filed within 72 hours after de Il Hyglene. other than "natural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Graphic Artist Aircraft 12 shoutd be filed w h and Mental Hygler 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ursula F. Yerger Richard R. Raezer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 is o Ursula Jane Harney/Sister 25 Hacks Point Road, Earleville, Maryland 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) Swarthmore, 20a. Method of Disposition July Date 14. permit. Pages Department of Important: If it any injury or o 0 1 Burial 2 Cremation 3 Removal from State Eastlawn Cemetery 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals 103 W. Stockton St., Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Muetaple Stab and Cuttine Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transit Due to (or as a consequence of): ending physician a use as the burial-Box 68760. pe Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed 1X Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1

Yes 2 □ No 2 Scene 28a. Date of Injury
(Month, Lay Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Certification: of or Attending for after death. Faring 5 Pending investigation 1 Natural 1 ☐ Yes 2 💆 No Stabled & Cut Subject 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 40 Lively Lane 6 Could not be 3 ☐ Suicide 4 X Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined. SIL ne Hospitel on 24 hours aft 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2XMedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier OCME M July, 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HR 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)
JUL 12 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month William Thomas Riley, Sr. July 8, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth
(Month, Day, Year)
April 20, 1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. 1 DM 2 □ F 025-10-8183 85 Director Yrs. Massachusetts Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Maryland Silver Spring Montgomerv Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1607 Belvedere Boulevard 20902 Items 23e USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ If Yes, Give WWII 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced 'neturat' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Cotlege (1-4or 5+) Real Estate Title Examiner Real Estate and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Riley Helen Teresa Burke 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health ar Importent: If item 27 is any injury or other trea William Thomas Riley, Jr./ Son 8318 Haven Hill Court, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 12, 2005 Fort Lincoln Cemetery ^¹ 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 22 Name and Address of Facility. Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, 21. Signatur of Funeral Service Licensee MD 20901 23a. Part1. Enter the disease, or cor 1 hations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only no cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End-Stage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dusto (Ji as a consequence oi). Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**√** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred after dea. rel Director: Afte 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hin 24 hours at the Funeral D mpletely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Vithin 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D0060038 ladmalatha 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padmalatha Reddy Moole, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901 32 Registrar's Signature 31. Date filed (Month, Day, Year, State 1 1 2005 Registrar

				For State		State	of Marylar	•	artment of rtificate o			_	gien Reg. N		21.000	_
				Registrar 1. Decedent's Nam	ne (First, Middle, I	Last)			imodic o	Dout		2. Date of De		2000	3. Time of Death	-
_	н	Physicia		Jacquel	ine	Elaine	Ric	chardso	n			Month (2) 7	O	2005	15:170	M
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		. Funeral Director		5. Social Security N 565-55-		.Sex 1	7. Age (In yrs. 42	last birthday) Yrs.	Months Day			8. Date of Bin (Month, Da 4/11/1	th l <i>y, Year</i> 963	r) 9. Birti Co Cal	nplace (State or Fore untry) ifornia	ign
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	Funeral Director		5. Social Security Number 214-34-9680 6. Security Number 1 Constitution of the security Number 214-34-9680 1 Constitution of the security Number 2		e (In yrs. last birthday 7 Yrs.	Months D		Under 24 Hours	Hrs. 8. Date of B (Month, D) 05/19	rth ay, Year) 1938	9. Birthp Cour	place (State or Foreign htry) MD
	aryland show	_	10a. State 10b. County		10c. City, Town or L						1	0d. Inside City Limits 1 X Yes 2 □ No
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	s 23a o	eral D	11 W. Baltimore St		Santa U.S. 140	2174				US		
960	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "natural", or Itams 23a or 28a-f show odher then "natural", or Itams 23a or 28a-f show event, the Medical Exemples of the foundation of the founda		11. Marital Status 1 □ Never Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Decedent If Yes, specify			? (Specify Yes or N uerto Rican, etc.)	Specif	ce - Americ ck, White, y: Wh	
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1212	filed within Hygiene. other then "		9 17. Father's Name (First, Middle, Last)	College (1-4or 5	,,,,	Housek			Name (First, Middle		otel	
Maryland 21215-0036		To Be	John Roy Nave				10		e May Wea		ne)	
Man	and and is m		19a. Informant's Name/Relationship (Ty. Harry E. Stotler	pe, Print) Compa / Husband	anion 196. Mail	ing Address (S V. Balt:	imore	Number o	r Rural Route Numb eet, Hage	er, City or Town,	State, Zip MD 2	1740
ore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P	emoval from State		matory or othe	er place)	0.7	Date	20c. Location		
Baltimore,	permit. Peg Department Important: I any injury o		'4 □ Donation 5 □ Other (Specify) 21. Signature of Eunoral Service Licen	98		2. Name and	Address o	f Facility	/15/2005 Gerald N. treet, Ha	Minnich	n Fun	eral Home
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each lir	the death. Do not er	iter the mode o	of dying, s	uch as car	diac or respiratory			Approximate Interval Between Onset and Death
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8760,	ate be executed hysician and the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	obs	100	v; Ps	c ku	ng Dis	ease	
O. Box 68	death certific e attending p ed for use as l	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death 3	□Ectopic pregi □ Other (speci					te of delive	ory Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death be	ut not resulting in the o	underlying caus	se given ir	n Part I.		tobacco use cont		ne cause of death? ably 4 Unknown
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Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	ent 2 🗆 ER/Outpatie	nt 3□DOA	Other		Death (Check only ig Home 5 ☐ Res		ar (Snacih	vI
ion of	Attending Phy r death. ector: After thi by the funeral o	Certification: T	27. Manner of Death 1	28a. Date of Injui (Month, Day	ry 28b. Time (. Injury at Work?	2 🗆 No		how injury occur		,
Division	el or Attus s after de il Directo id in by t	Sertific	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, o	office			(Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best oner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	th occurred at to restigation, in	the time, o	date and pon, death o	ace, and due to the courred at the time	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	Juhn		29c. L	icense nu	GO 1	396	29d. Date signe	d (Month,	Dey, Year)
H-	4		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	, Print)	112	6	opal	y m	0 1	1740
	Sta Registr		31. Date filed (Month, Day, Year) 3 20		ar's Signature	perk		176-6	7)	`	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ANNE Μ. STIERS JULY ,2005 0115 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BROOKE GROUF REHABILITATION AND NURSINGCENTER SPRING SANDY MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1□M 21 F Months Days Hours Director 073-16-0741 84 March 22 1921 Scotland Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Va. Arlington None or 28a-f 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 2530C South Walter Reed Drive 22206 United States Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: ō Baltimore, Maryland 21215-0020 δ 1 ☐ Yes 2 ☐ KNo Specify: 3 ☑ Widowed 4 ☐ Divorced Specify. naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 27 is marked other it traumatic event, !! 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill tment of Health end Mental H Be 18. Mother's Name (First, Middle, Maiden Surname) David McGuire Mary-Anne Maquire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health en important: if item 27 is eny injury of 2ther train once. Michael J. Stiers / Son 2530C South Walter Reed Dr., Arlington, Va. 22206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/11/05 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home in P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a MYDCARDIAL INFARCTION Examiner MNUTES Due to (or as a consequence of) Physician/Medical Examiner ATRIAL FIBRULATION The law requires that the death certificate be executed ettending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SCHIZOAFFECTIVE DISORDER 1 Yes 2 No 3 ☐ Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete has 1 ☐ Yes 2**X** No 1 ☐ Yes 2 ☐ No Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home ၉ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Director: / 1 Yes 2 No 6 Could not be determined 3 Suicide within 24 hours effer unitarity To the Funerei Direct Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IN ATTENDING PHYSICIAN 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) AN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND
32 pregistrar's Signature GENCE BROOKE HUFFMAN 31. Date filed (Month, Day, Year) State 12 Registrar

DHMH 16 Rev 6/95

Registrar
DHMH 17 Rev 1/2001

0 8 2005

			For State Registrar	State of	Maryland / Dep	artmen e <i>rtificat</i>						2005	21. 3	210
	•		Decedent's Name (First, Middle	le, Last)						2. Date of Dea	ath		3. Time of	Death
	Physici /Medic		Thomas Louis S	Shutt						Month 07	1 4	05°	3:30	Ам
)	Examin		4a. Facility Name (If not institution	•	er)			Location of			4c. 0	County of Death		
			4031 Wilkinson Ros		Ago //p.um lost high de		vre (de Gr		O Data of Bird		Harfo		
P	Funeral Director		5. Social Security Number 213–40–1155	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. last birthda, Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day 11/14/1	942	1	nplace (State ountry)	or Foreign
	D		Usual Residence of Decedent									Mary	land	
	arylar show	-	MD Harfe		10c. City, Town or	Location e de Gi	r						10d. Inside C	ity Limits 2 ☐ No
	the M	ecto	10e. Street and Number		navie	10f. Zip					10a Citiz	en of What Co		2
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show lical Examinat must be redified at	Funeral Director	4031 Wilkinson	n Road		210					rog. Citiz	USA	intry:	
	death	nera	11. Marital Status	12. Was Decede		. Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race - Amei		
36	or Ite		1 ☐ Never Married 2 ☑ Mar	ried 1 ☐ Yes 2 If Yes, Give	X No	1 Yes		Specify:	1, 1 49110	riicari, Gio.,		Black, White Specify: Wh	ite	
21215-0036	hours turel',	ed by	3 Widowed 4 Divorced	Year or Date		edent's Usua						, , , , , , , , , , , , , , , , , , , ,		
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nd	be filed within 72 hours after death with the Marylan itat Hygiene. od other then "neturel", or Items 23a or 28a-f show event, the Madical Exambre must be redified at	Be	17. Father's Name (First, Middle, John Louis Shi							e <i>(First, Middl</i> e, Marie P				
Z	should be nd Menta marked umetic ev	မ	19a. Informant's Name/Relations		105.14		(5)							,
Maryland	ges 1 and 2 should it of Health and Mer If item 27 Is marke or other treumetic		Darlene Ann Sh			_				al Route Numbe avre de			21078	
	s 1 an of Heal item 2		20a. Method of Disposition		20b. Place of Dis					Date		ation - City or 1		
E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		Mt. Zior				7/18	/2005	Be1	Air, M	D	
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Licenspor		22. Name an				c.,600 Ma	in St	.,Delta,	PA 1731	4
г			23a. Part Enter the disease, o shock, or heart failure. List	reor plications that cau	sed the death. Do not e	nter the mod	e of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximat Interval Bet	
	Physician		Immediate Cause (Final disease or condition	A	KDS								Onset and	
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	cimo	100	71	1	1 /F	um	iex	GM	
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16	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S					1					
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8760,	death certificate be executed e attending physician and nd for use as the burial-transit	lical		d	-									
9	eath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outco	ma of programmy									
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	n 2 Fetal death 3	☐Ectopic pr					23	3d. Date of deli- Month		Year
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Ä	The ate h page	Com								autop perfor		death?	ompletion of c 2□ No	ause or
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OU	Attending I r death. sctor: After by the funer	tlon	1 Natural 5 ☐ Pendi	28a. Date of (Month, igation	Day Year) Injury	M	8c. Injury Work 1 [] `	(? Yes 2 🔲		Lod. Describe II	ow injury	occurred		
Division of	l or Attendi after death. Director: A in by the fu	ertiflcation:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	Injury - At home, farm, s , etc. (Specify)	street, factory	, office			28f. Location (S City or Tow	itreet and	Number or Ru	ral Route Num	ber,
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyii (Check only one) 2 Medical	Examiner: On the bas	est of my knowledge, des s of examination and/or	ath occurred investigation	at the tim , in my or	ie, date an pinion, dea	d place, th occurr	and due to the d ed at the time, d	ause(s) a date and p	and manner as place, and due	stated. to the cause(s	;)
	To the within 2 To the comple	Mec	29b. Signature and title of certific	and manne	stated.	290	License	number.			29d. Date	signed (Month	, Day, Year)	
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	,		30. Name and address per on	who call pli ted conse	of e th (Item 23.) (Type	e, Print)		5,0				T	21	201
	10		YEIK HAL	ANTH	11D 22	SOUT	# G	REE	INE	- STK	551	BAU	HURL	IND
	Sta Registr		31. Date filed (Month, Day, Year,		istrar's Signature	adi)					/			/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Junty 0900 Haro1d Lee Smith 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Federalsburg 3441 Williams Street H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8, 1955 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 221-40-2676 1 XM 2 ☐ F 49 Director Delaware Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Federalsburg Caroline MD Completed by Funeral Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 3441 Williams Street United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2XXo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Manufacturing Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George M. Smith, Jr. Lillian L. Stewart Fountain 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3441 Williams St., Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type, Print) Emma Baynard/Companion 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Federal Hill Cem. 07/16/05 Federalsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): PNSIDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed Box 68760. P.O. | signed to Division of Vital Records. Hospitel or Attending Physicien: this After within 24 hours after death.

To the Funerel Director: A completely filled in by the fire death.

Physician

burial-transit

the use as t

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number De laware 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and dd ess of person who complet cause of death (Item 23a) (Type, Print) mas Lagenta der (Month, Day, Year) 132. Registrar's Signature 8 2005

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Year Day July **Physician** 14, Mary E. Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Hart Heritage Estate Assisted Living Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/12/1921 9. Birthplace (State or Foreign Country)
Virginia 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Director 218-42-4056 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Forest Hill Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21050 2735 Grier Nursery Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X∑ Yes 2 □ No If Yes, Give Year or Dates: 1942–46 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other traumatic event, Ite Mustle 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Roberts 2 William Wyche Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Bower Lane, Forest Hill, MD 21050 (Son) Steve H. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/19/2005 Forest Hill, MD Deer Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A 333 S. Parke St. Aberdeen, MD 21001 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZheimers yenns END STAGE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Completed by Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day for 5 Other (specify) PO detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 28 No 1 ☐ Yes Division of Vital Hospitel or Attending Physician: MSISHEN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence ther (Specify) CARR Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Ē 10 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after deat Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7 39889 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar W. MALPHAIL

BULAIN MD. 21019

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ALFRAD

31. Date filed (Month, Day, Year)

615.

. Registrar's Signature

	1		1 - For State Registrar	State of Maryla		artment of F		Mental Hyg	piene 2005	24316
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
	Physici /Medic		SHELDON K.	SPEARIN	IG			July 6	Day Year 2005	7:00 p M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			6006 85th Plac	e		New Carı	rollton		Prince (eorge†s
	Funeral			S. Sex 7. Age (In yrs		If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		rthplace (State or Foreign ountry)
	Director		173-14-3436	18 2UF 85	Yrs.	Monano Dayo	110010	October	8, 1919 Pe	nnsylvania
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation	•			10d. Inside City Limits
	/ sho	5								1 Yes 2 No
	28a-	Director	Maryland Prince	George's Ne	ew Carr	OLLton 10f. Zip Code			l 0g. Citizen of What C	
	with a or	ă	6006 85th Plac	_						ountry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	20784 Was Decedent of F	dispanic Origin? (Sp	ecify Yes or No-	U.S.A.	erican Indian
"	riter	핊	1 Never Married 2 Marrie	Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
036	al', o	þ	3 XWidowed 4 ☐ Divorced	If Yes Give	JII	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	within 72 hours effer deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madical Examiner mast be malified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occup	pation during most of work		16b. Kind of Business	s/Industry
21	within ene. then "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	ang		
	filed wi Hygien ther th	Con		4	Acco	untant			U.S. Gove	ernment
pu	tal H d oth	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Z a	2 should be f and Mental F is marked of aumatic ever	٩	William Spearin	-			Wanda B	0		
Maryland	12 sh n and is rr raurr		19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Town, State.	Zip Code)
	s 1 and 2 should be filed within 72 hours efter deeth with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene transity is marked other than "natural," or Items 23a or 28a-f show other traumatic event, the Medical Examinar mast he notified at		Donna Roat - No. 20a. Method of Disposition			04 Windbro			n, Marylan	
Baltimore,	permit. Pages 1 a Depertment of Hes Importent: If Item any injury or othe		1 🗆 Burial /2 🛱 Cremation	3 □Removal from State	cemetery, cre	matory or other pla	ce)		20c. Location - City o	
Ħ	permit. Pages Depertment of Importent: If if any injury or c		`4 □ Donation b □ Other (Sp	122			ory 7/8/		Alexandria	, Virginia
Bal	permit. Depertrimporte importe any inju		21. Signature of Funeral Service	conset /					meral Home	
	40.200		220 Part Splay the disease of	amplies and the dead the dea					sville, M	
			23a. Fart Enter the disease, or o shoot, or heart faifure. List o	nly one cause on each fine.	ith. Do not en	ter the mode of dyir	ng, such as cardiac			Approximate fnterval Between Onset and Death
	Physician /Medical		Immediate Cause (Finat disease or/condition resulting in death)	_a.//	1181	namy	ave	dis	case	3.1331 4113 33411
	Examiner		,	a. Due to (or as a conse	quence of):	0.1.		1		
		-i-	Sequentially list conditions, if any, leading to immediate	b	guence of):	flerten	Sim			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1						
Ć.	exec an an	Exa	resulting in death) Last	C. Due to (or as a conse	quence of):					
8760,	The law requires that the death certificate be executed the bes been signed by the attending physicien and page 2 should be detached for use as the burial transit	cai	al I	d						
9	death certifica attending ph d for use as th	Physician/Medical	I F F F MAI F							
Вох	th ce tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregnanc	v		23d. Date of de	
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (specify)	,		Month	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown							
	res tha igned be det	by	Part ff. Other significant condition	s contributing to death but not re	sulting in the L	inderlying cause giv	ven in Part I.		bacco use contribute	
ecords,	w requir been si should	Completed						1 UY	es 2.21No 3F	robably 4 Unknown
ec	a law	npie						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
R	(0)	Cor						perfor 1 ☐ Yes		s 20 No
Vital	sician: The law certificate hes t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat			
of	this ald	D	1 Yes 2 No 27. Manner of Death	1 Inpatient 2L	ER/Outpatie	nt 3 DOA			ence 6 Other (Spe	ecify)
U	ding After fune	ion	1 ☑Natural 5 ☐ Pending		28b. Time o Injury	Wor		28d. Describe h	ow injury occurred	
Si	Attending in death.	ical	2 ☐ Accident investigated investigated and a could not be a could	ot be 390 Blace of leiung At I	nome form et		Yes 2 No	28f. Location (S	treet and Number or F	haral Cauta Mambas
Division	after Dire	Certification:	4 Homicide determin	building, etc. (Spec	ify)	reet, ractory, office		City or Town	n, State)	urai Houte Number,
_	ours ours nerel filled		29a. Certifier 1 Certifying	Physician: To the best of my kn	owledge deal	h occurred at the ti	me, date and place	and due to the c	ause(s) and manner a	s stated
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical E	xaminer: On the basis of examin and manner stated.	ation and/or in	vestigation, in my c	ppinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	Mithin To th	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
	1.) WE	-1 105	9	- 1)	84717)	7 71	0)
_	LIVA		30. Name and address of person w	no completed cause of death (Ite	m 23a) (Type.	Print)	-1 /1 2		1 1	<u> </u>
	BC.		Madhu K. Mohan,				#220, Box	vie. Mar	yland 2071	6-3104
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig						
	Registr	ar	JUL 1 2 2005	Deliver to 19						

	*		1 - For State Registrar	State	of Maryla		artment rtificate				lental Hyg	giene	105	21.317
	_		Decedent's Name (First, Middle,	Last)			modio		Joann		2. Date of Dea		00	3. Time of Death
	Physici		JACK ELISHA	STR	EET, JR						Month July	Day 7	2005	1:49 P M
	/Medio Examin		4a. Facility Name (If not institution,				4b. City, T	own, or	Location of	of Death	J	4c. Cou	inty of Death	
			Washington Adv	entist	Hospita	a1	Tako	oma	Park			Mon	tgomer	У
	Funeral			6. Sex 1)X M 2 □ F		s. last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	Cou	place (State or Foreign
	Director		489-20-7940 Usual Residence of Decedent	A W ZU	79	Yrs.					Mar. 1,	1926	St. I	ouis, MO
	and w		10a. State 10b. County		10c. C	City, Town or Lo	cation				· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary 1 sh	ţ	MD Prince	George'	e Hva	attsvil.	16							1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	COLGE	5 1190	*CCD V 111.	10f. Zip C	Code			1	0g. Citizen	of What Cou	ntry?
	th with		7204 West Park	Drive			2	078	1			U	.S.A.	
	ems erms	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ameri	
9	or It	y Fu	1 ☐ Never Married 2 Marrie	ed 11X1Yes If Yes, G	2□No 19	44-	1 □ Yes 2)		Specify:		riioari, etc.)		Black, White,	etc.
Š	hours tural'	d by	3 Widowed 4 Divorced	Year or I	Dates: 197	71							Bla	
Ϋ́	filed within 72 hours after death with the Maryland Hygiene. other than "netural", or Items 23a or 28a-f show ent, the Medical Exantrer must be notified at	Completed	15. Decedent' (Specify only highest	grade completed		(Give	ient's Usual kind of work DO NOT use	done a	luring mos	t of worki	ing	16b. Kind o	f Business/In	dustry
2	with iene.	omp	Elementary/Secondary (0-12)	College 3	(1-4or 5+)		. Navy					Yeoma	an	
ğ	filed Hyg other	BeC	17. Father's Name (First, Middle, L	ast)			2.02.7				e (First, Middle,			
<u>a</u>	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "netural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	To B	Jack Elisha Str	eet					Anna	bell	e Roger	S		
Maryland 21215-0036	2 should and Men Is marke		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a			al Route Number		wn, State, Zij	Code)
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic esones.		Claudia M. Stre	et, Spou						ve,	Hyattsv	ille,	Mary1	and 20783
ore O	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	20b.	Place of Dispo cemetery, crer	sition (Name	e of ner place	9)	C	Date	20c. Locatio	on - City or To	own, State
Ě	Pages ment of ant: If It lury or o		`4 Donation 5 Dother (Sp			raham Li	ncoln M	lem.	Cem. (07/14	4/2005 E	lwood	, Illi	.nois
Baltimore,	permit. Departn Imports any inju		21. Signaturo Eureral Service L	icensee		22	. Name and	Addres	s of Facilit	y Gas	ch's Fu	neral	Home,	P.A.
	₹0 5 € Ø		Value / Km	199	10137						ue, Hya		lle, M	aryland
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that only one cause on	caused the de each line.						or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		ehli	cae	20	ne	3				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	quenca di):	Cero							
		-	Sequentially list conditions,	b	(or as a conse	difference of).								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	50010	(0) 43 4 20/130	querice ory.								
,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	cDue to	(or as a conse	quence of):								
8/e0	The law requires that the death certificate be executed at has been signed by the attending physicisn and bage 2 should be detached for use as the burial-transit	dicail		d										
Q	tificat ig phy as th	ledi												
X Q Q	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregr		Ectopic pred					23d.	Date of delive	ery
	deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (spec						Month	Day Year
r Ö	at the de by the a	Phy	9 Unknown								_			
Ś	w requires that been signed to should be deta	by	Part II. Other significant condition	s contributing to c	leath but not re	sulting in the u	nderlying cau	use give	n in Part I.					ne cause of death?
cord	een s	ted		anju	illy						1 L Ye	s 2 No	3 Prob	pably 4 X Unknown
ပ္	e law has b	Completed									24a. Was a autops	y	prior to co	psy findings available mpletion of cause of
<u> </u>		S									perforr 1 ☐ Yes 2	ned? ZXINo	death? 1 Yes	2 🗆 No
VItal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otha	_		(Check only on			
ö	Phys this ral du	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of			4 🗆 140		ne 5 Reside			y)
0	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Mor	nth, Day Year)	Injury	M	C. Injury Work	at ? ′es 2.⊟ñ		28d. Describe ho	w injury occ	curred	
UNISION	Attending ir death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no	t ho	e of Injury - At i	home, farm, str			00 20	-	28f. Location (St	reet and Nu	mber or Rum	I Route Number.
É	after Dire	ert	4 Homicide determin	build	ling, etc. (Spec	home, farm, str ify)	,,,				City or Towr	, State)		
	Hospital		29a. Certifier 1 ☐ Certifying	Physician: To the	e best of my kn	lowledge, death	occurred at	the time	e, date and	d place, a	and due to the ca	ause(s) and	manner as s	tated.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tr	edicai	(Check only 2 Medical E	xaminer: On the t	asis of examin iner stated.	ation and/or inv	estigation, in	n my op	inion, deat	h occurre	ed at the time, da	ate and plac	e, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. l	License	number	, ,	2	9d. Date sign	ned (Month,	Day, Year)
	10							5	6/	4/		11	110	F
	Cin		30. Name and ad less of person w		se of death (Ite	m 23a) (Type,	Print)					/	/	
	104		DR. NASREEA	Je KAN	80 1	m 23a) (Type,	CAR	101	/ A.	JE .	7.6	mI). 4	0912
	Sta Registra	_	31. Date filed (Month 2005 ear)	Oldver 2.	li al S									
	4			,										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** James Darrell Sprague 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lanham Prince George Doctor's Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊊**M 2□F Months 577-46-0463 Director 3, 1933 Washington, Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George Cottage City or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 United States 3711 43rd Avenue permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a any injury or other traumatic event, the Medical Ferror 200.00. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 反 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland 12 Plummer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ida K. Stuehm Raymond E. Sprague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 43rd Avenue, Cottage City, M.D. Jean Rene Judeson/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Brentwood, Maryland Fort Lincoln Cemetery 7/9/05 22. Name and Address of Facility 21. Signature of Funeral Service L Lincoln Funeral Home Bladensburg Road, Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to innividual cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No funeral 28c. Injury at Work? 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 | Homicide lilled 29a. Certifie 1 🐧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Luck Rd, Ste 302. Ko nomas 8100 31. Date filed (Month, Day, Year) State 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

						Certific				Reg. No.2	5 21310
П	Physic	cian	Decedent's Neme (First, Middle, La						2. Dete of De	ath Dev Ye	3. Time of Death
	/Med		Mary L.	Scheid					July 6	, 2005	7:08 PM
	Exam	iner	4a Fecility Neme (If not institution, giv	e street and number)				4b. City, Town, or I	Location of Deeth	4c. County of D	Peeth
			Carriage Hill	1 - 12		Will Will		Bethesda		Montgom	
	Funera Directo		5. Social Security Number 218-34-5020 6. S Usuel Residence of Decedent	ex 7. Ag	e (In yrs. las 94		nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da July 29	y, Year) 9,1910 II	Birthplace (State or Foreign Country) linois
	and and		10a. State 10b. County		10c. City, 7	Town or Location					10d. Inside City Limits
	Se-f sho	Director		gomery	Beth	nesda					1 AYes 2 No
	ter death with the Marylan terms 23e or 28e-f show ther must be notified at	rai Dire	10e. Street end Number 4853 Cordell Ave	nue #601		10f	Zip Code	0814		10g. Citizen of What USA	Country?
020	n 72 hours after daath with the Maryland "nature!", or flems 23e or 28±f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:	Ever in U,S. No		ecedent of F specify Cub s 2 X No	dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)	14. Raca - A Black, W Specify:	merican Indien, Vhite, etc. White
Ş.	72 h natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	16e. Decedent's l	Jsual Occup	ation during most of wor	kina	16b. Kind of Busine	ess/industry
2121	d within	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Teache		during most of word)		Montgome	ry County
פ	othe othe	Be	17. Father's Neme (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
<u>a</u>	uld b Vante	ToE	Patrick Devine					Anna	Bourke	1	
a	2 sho end i		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Add	ress (Street	and Number or Ru	ıral Route Numbe	er, City or Town, Stat	e, Zip Code)
2	and ealth n 27	- 4	John Scheid/Son		-	4853 Coa	dell	Ave.,#60		sda, Md.	
Baltimore, Maryland 21215-0020	pemnit. Pages 1 and 2 should be filed Department of Health end Mantel Hyg Important: if Item 27 is marked other eny injury or other traumatic event, once.	b	20a. Method of Disposition 1			e of Disposition (etery, crematory Gabriel			July 13, 2005	Potomac.	or Town, State Maryland
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licer	18020	1			ss of Facility De	Vol Fune	ral Home	
			23a. Part Enter the disease, or com shock, or heart failure. List only	plications that caused	the death					_	Approximate Interval Between
A STATE OF THE STA	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Pneumor	nia, A	spirations a consequence	n				Onset and Death
Ö,	e axecut lan and unal-tran	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			s a consequence Disease	of):				
Box 68760,	certificate be axecuted nding physician and use as the bunal-transit	5	Cause (Disease or Injury that initieted events resulting in death) Last	0.		s e consequence	of):				
ň	death cei e attandir ed for use	Ca	Part II. Other significant conditions o	patributing to dooth by	it not requitie	a in the undertwin	30 00 U00 air	on in Port I	22h Bidd	ahaaa uaa cantrib	ute to the cause of death?
. P.O.	es that the death ce igned by the attand be datached for us.	y Physician/	Dementia	Simboling to death bi	at not resulti	ig in the underlyit	ig cause giv	en in Pail i.			Probably 4 Unknown
Division of Vital Records,	ew requir as been s 2 should	Completed by								an autopsy 24 med?	ib. Were autopsy findings available prior to completion of cause of death?
<u> </u>	0 - 0	9							101	65 Ž LNo	1 ☐ Yes 2 ☐ No
<u>Ita</u>	iclan: The certificate irector, peg	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)	
5	Physician: this certific rel director,	၉	1 ☐ Yes 2 ☐ No		nt 2 ER		DOA Oth	44E INDISHING IT		lence 6 □Other (S	Specity)
<u>0</u>	Attending P ir death. actor: After t by the funere	ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	Year) 28	Bb. Time of Injury M	28c. Injur Wor 1 □	yet k? Yes 2 □ No	28d. Describe h	now injury occurred	
Divis	P afa	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Injubulding, etc		e, farm, street, fac	etory, offica		28f. Location (S City or Tox		r Rural Route Number,
	the Hospital hin 24 hours the Funeral uplataly filled	edical	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of liner: On the basis of and manner sta	examination	dge, death occur end/or investiga	red at the tir tion, in my o	ne, date and place pinion, death occu	, and due to the orred et the time,	cause(s) and manner date and place, and o	r as stated. due to the cause(s)
	To the Within 2 To the compla	M	29b. Signature and title of certifier	- 1			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
			Durm	W	bo		D3	35579		July 7, 2	005
_	10		30. Neme end address of person who susan J. Miller.		•	, , , , , ,	Terra	ice Rot	heads N	Id. 20816	
1	St Regist	ate	31. Date filed (Month, Day, Year)	3 Registra	ar's Signeture		TOLLO	тес пес	nesua, M	14. 20010	

Gene R. Stull 05-04603 crn

		State of Maryland / Department of Health and 1 - State State Certificate of Death	•	20	0= 0:000
Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Reg. No.	Year (3:47 PM
/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea Conversity of Mary Land BALTIMO		4c. County	
Funeral Director		5. Social Security Number 214-34-9847 G. Sex 7. Age (In yrs. last birthday) 11 Under 1 Year Months Days Hours Mir Usual Residence of Decedent		y, Year)	9. Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28e-f show rmust be notified at	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
ath with the 23a or 28 unt be not	i Director	10e. Street and Number 10f. Zip Code 5611 Bartonsville Road 21704		10g. Citizen of W	-
ĕ ≗ ≅	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	14. Race	o - American Indian, k, White, etc.
15-0 n 72 ho "netur	Completed		orking	16b. Kind of Bu	
Aaryland 212 2 should be filed withi and Mental Hygiene. 1s marked other then reumetic event, the M	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's National Control of the Con	ame (First, Middle, Grace		9)
C = 64 F		19a. Informant's Name/Relationship (Type, Print) Dorothy A. Stull / Wife 19b. Mailing Address (Street and Number of F			State, Zip Code) 21704
Baltimore, I bernit. Pages 1 and bepartment of Healt mportent: If item 2 inty injury or other 100s.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem.Garden 07/1	Date 13/2005		City or Town, State
Baltime permit. Pag Department Importent: I any injury o		Saymond beleran 1621 Opossumtown	Pike / F	rederick	Homes, P.a. ,MD 21702
ate be executed The purial transit the burial transit	ai Examiner	23a. Part 1. Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	NTURY THOM REPROVED BY	04.0	Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/60, The law requires that the death certificate be exite has been signed by the attending physician page 2 should be detached for use as the burial	by Physician/Medica			-1	e of delivery
rdS, P., quires that the signed by ald be detact			23e. Did to	ad	bute to the cause of death?
	Completed		24a. Was autop perfor 1 \(\text{Yes}	rmęd? de	/ere autopsy findings available rior to completion of cause of eath? Yes 2 No
on of ding Phys h. After this funeral di	Certification; To Be	examiner? 1 Yes 2 No Hospital: Apatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Fall de 28f. Location (S City or Tou	lence 6 Othe now injury occurred OWN a fl.	ight of stairs
pite ours ours illec	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place and manner stated.	e, and due to the	cause(s) and man date and place, a	nner as stated. Indidue to the cause(s)
	Med	29b. Signature and the dentities AUHIT-6H3	35F15410	29d. Date signed	(Month, Day, Year) 08 105
10+1VA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID FARCY MO22 SOUTH Creever 51 Balti	more, Man	ryland 2	1201
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 2 2005			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** July 10, Carol Ann Smith 1:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4003 **16th** Street Chesapeake Beach Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 1, 1948 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2X F New York 131-38-3971 56 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itsm 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumetic event, the Madical Examinar must be notified at MD Calvert Chesapeake Beach 1 Yes 2 □ No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4003 16th Street 20732 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2X Married ☐Yes 2⊠No Maryland 21215-0036 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) 12College (1-4or 5+) Massage Therapist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Thoomey Emma Apsel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Nicole Brown (daughter) 2181 Plum Point Road Huntingtown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 13. 0 = 1

Burial 2 □ Cremation 3 □ Removal from State ŏ rtant: 1 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Grdns. 2005 Dunkirk, MD permit. 21. Signature Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Deport Import any in Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** years cancer Lyno resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events memia Due to (or as a consequence of): inding physician and use as the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) P.O. I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by Yes been signated 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? rector, page 2 1 Yes 2 1 Yes 2 No or Attanding Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 | Inpatient 2 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 TYes 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After Division Natural 5 | Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation М Director: / d in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Voithin 24 hours at To the Funeral Directory Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ths. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) OS D0059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Patel, MD 110 Hospital Road Ste 212 Prince Frederick, MD 32. Registres Signature 31. Date filed (Month, Day, Year) State JUL 1 2 2005 > Registrar

			State of Maryland / Department of the State	artment of Health and Mer		2005 24322
			Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
	Physici /Medio		Kip Elizabeth Smith			005 11:45 A.M
	Examir	ier	4a. Facility Name (If not institution, give street and number) 486 Redwood Road	4b. City, Town, or Location of Death Lusby	1	alvert
	Funeral		5 Social Security Number 6 Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs. g	Date of Birth	9. Birtholace /State or Foreign
	Director		240-26-4934 1 M 2 F 82 Yrs.	Months Days Hours Min.	ig. 10, 11	922 North Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation		10d. Inside City Limits
	Mary I sho	to	Maryland Calvert Lusby			1 ☐ Yes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
	ath wi		486 Redwood Road	20657		ted States
	iter de	Funeral	1 Chause Married 2 Adams 1 CVos 2 No	Vas Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica	an, etc.)	 Race - American Indian, Black, White, etc.
036	ei', or	þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	Yes 2 No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "naturei", or items 23a or 28e-f show Ita Maulcal Exar-ilirer reast be indiffied at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	ent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. K	Kind of Business/Industry
121	within ene. then	dwo	Flementary/Secondary (0-12) College (1-40/5+)	il Records Coder	Hea	lth Care
1d 2	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maider	
ylar	Mental Mental arked catic sve	To E	Clarke Drake	Mary Battl		
Maryland	d 2 sh th and th and 7 is m treum		1,7,7,7	g Address (Street and Number or Rural Ro Ledwood Road, Lusby,		
	s 1 an f Heal item 2 other	1	20a. Method of Disposition 20b. Place of Disposition completely grant			ocation - City or Town, State
E O	Pages nent of ant: If it ary or o			oln Cemetery 7/14/20	005 Brei	ntwood, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Importent: if them 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other treumatic event, II a Marilical Extr. iling reast by nutilised all QRCS.		21. Signature of Funeral Service Licensee 22 MOO542	Name and Address of Facility Rauso	ch Funeral	l Home, P.A. Republic, MD 20676
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition a	CANER		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence -):			
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
	cuted	Examiner	that initiated events c.			
8760,	ate be executed hysician and the buriat-transit		resulting in death) Last Due to (or as a consequence of):			
687	icate I physics the b	edical	d			
Box (death certifica e attending ph id for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of delivery
O. B		Physician/Med		Other (specify)		Month Day Year
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	quires an sign uld be	ed by			1 Des 2	□ No 3 □ Probably 4 □Unknown
Records,	e taw requir has been s je 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>س</u>	Th ate pag				performed? 1 ☐ Yes 2 ☐ No	death? 1 □ Yes 2 □ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Control of the Control of the C		6 COther (Specify)
of		⊢ ;	27. Manner of Death 28a. Date of Injury 28b. Time of		. Describe how inju	
sior	Attending F ir death. sctor: After by the funera	catlo	2 Accident investigation	M 1 Yes 2 No		
Division	or A fter Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office 28f.	City or Town, State	nd Number or Rural Route Number, 9)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or inv			
	ths Hi hin 24 ths Fi	Medical	one) and manner stated.	29c. License number		te signed (Month, Day, Year)
,	wit 70		29b. Signature and title of certifier	041314		y 11, 2005
	. ~		30. Name and address of person who completed cause of death (Item 23a) (Type, I		Dury	y 11, 2005
	5		Paul V. Pomilla, M.D. 110 Hospital Ro	ad, Suite 310, Prin	ce Freder	cick, MD 20678
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 2 2005 Street JUL 1 2 2005	South		
	J		7			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year July 2005 Donald Lee Sinback /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 11244 Dancer Court Lusby Calvert 5. Social Security Number 125–36–5722 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MCountry) **Funeral** Days Hours 1**X** M 2□ F 60 Months Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits Injury or other traumatic event, the Medical Examinar must be notified at MD Calvert Director Lusby 1 ☐ Yes X☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itema 23a 11244 Dancer Court 20657 by Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "natural", or its any Injury or other traumation. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ogistics Management Specalist U S Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Warner Randall Sinback Lyla Berggren 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Sinback (Wife) 11244 Dancer Court, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 7/6/05 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License MOO5424405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy O in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 🗆 No 2**X** No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after dec. Injury 1 □Yes 2 □No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDORF 31. Date filed (Month, Dav. Year) 32. Registra s Signature State 2005 Registrar

CARY 900-28-6864

4c. County of Death **Examiner** Regional Medical eninsula WILDMILD If Under 24 Hrs.
Hours Min. If Unde 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year Days 8. Date of Birth Month Day Year JUNE 22,1959 9. Birthplace (State or Foreign **Funeral** 1**X**0 M 2□ F DELAWARE 221-56-8508 46 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at SUSSEX GEORGETOWN DE 1 ☐ Yes 2 ☐ XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20446 STATE FOREST RD. 19947 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ō WHITE by Specify: Specify 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any nijury or other traumetic event, Ite 9008. 12 MASON MASONRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STOECKEL SYLVIA DOWNES GERALD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2546 DUPONT BLVD. GEORGETOWN, DE 19947 GERALD STOECKEL - FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State COKESBURY CEM. 4 ☐ Donation 5 ☐ Other (Specify) 7-12-05 GEORGETOWN, DE 22. Name and Address of Facility SHORT FUNERAL SERVICES 21. Signature of Funeral Service Licensee 204 609 E. MARKET ST., GEORGETOWN, DE 19947 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an YN -0 K /Medical Due to (or as a consequence of): **Examiner** Tracisar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner le. 0 that initiated events resulting in death) Last CERTIFICATION APPROPRIATE MEDICAL EXPLANATION OF THE PERSON OF THE PERSO The law requires that the death cartificate be exec Due to (or as a consequence f): 68760 by Physician/Medical Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 Natural 2029 1 Yes 2 No July 5,2005 Motorcyclist struck an object 2 Accident in by the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number of Reval Route Number of Reval Ro 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide roadway within 24 hours a To the Funeral C 1 Certifying Thysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CAMOUL St. SAlisbuny Md DAVID WALKER MD 31. Date filed (Month, Day, Year) JUL 2 5 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

2. Date of Death

Year

2005

State of Maryland / Department of Health and Mental Hygiene
1- For Amend Item 25&28a-f per me G845 7-22-05 tas

Certificate of Death

Read NO.

STOECKEL

1. Decedent's Name (First, Middle, Last)

RAY

4a. Facility Name (If not institution, give street and number)

GARY

Physician

/Medical

			For State Registrar	State of	Maryla	nd / Depa	artment			and M			005	24325
	5 1		Decedent's Name (First, Middle, Las	t)		_					2. Date of De			3. Time of Death
	Physici /Medic		Samuel	Traner	1						July	8, 2	005 Yea	4:35 A M
	Examin		4a. Facility Name (If not institution, give		iber)				Location o	of Death			County of De	
			Suburban Hospital		7 4 //	la as bishbulasi	B If Under	ethe	sda If Under:	24 Hrs. 1	0.0		Montg	
	Funeral Director		5. Social Security Number 6. Se 578-36-5666	M 2□F	7. Age (in yrs 94	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 4	v. Year)	9. E	Birthplace (State or Foreign Country) ew York
			Usual Residence of Decedent		<i>J</i> +						July 4	, 191	1 1	ew IOIK
	nylani how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	e Ma	cto	Maryland Montgome	ry	Ве	thesda								1 ☐ Yes 2√ No
	ith th	Dire	10e. Street and Number				10f. Zip					_	en of What	
	s 23e	eral	6101 Eastview Stre		daat Evas in I	15 12	Wa- D		817	-:-0.10	- '4 - W N -		ed St	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury ordiger traumette event, the Medical Evanthan must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2X∏No e		was Deced If Yes, spec			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Black, Wi Bpecify:	merican Indian, hite, etc. white
Ö	2 ho	ted	15. Decedent's Ed			16a. Dece	dent's Usua	I Occupa	ation	4 - 4		16b. Kin	d of Busines	
21	thin 7	nple	(Specify only highest grades Elementary/Secondary (0-12)	College (1	4or 5+)	life.	kind of wor DO NOT us	e retired))	e or workii	ng			
7	ygier ygier her th		47.5 11 1 11 15 15 14 17 17 1	1		Busi	ness (Owne			(-		iquor	
and	be fill ad ott	Be	17. Father's Name (First, Middle, Last) Morris Trane	n					18. Mothe		(First, Middle,	Maiden S Nolfs	,	
Ž	hould d Mei mark matic	잍	19a. Informant's Name/Relationship (7			10b Mailie	ag Addross	/Street s			i Route Numb			Zin Codo)
N N	nd 2 s Ith an 27 is :		Gloria Cornblatt,	daught	er									ens, FL33418
re,	Item Item		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer					ate			or Town, State
E	Page lent o nt: if		1X Burial 2 □ Cr mation 3 X 4 □ Donation 5 □ Other (Specify							7/10	/2005	Falls	s Chur	ch, Virginia
Baltimore,	permit. Departm Importa any inju		21. Signature of Fune al Service Licer	see	,						l Direc			
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			23a. Part1. Enter the disease, of company shock, of heart failure. List only	lications that canno cause on ea	used the dea									Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):								
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	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Usease or injury			1								
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8760,	death certificate be executed te attending physician and yd for use as the burial-transit	dlcal		d										
9	ntifica ing ph e as th	Med	IF FEMALE:											
Вох	leath certific attending p	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fet	aldeath 3	Ectopic pre					23	Bd. Date of o	delivery Day Year
<u>o</u>	the a	yslc	1 Yes 2 No	4∐Pregn: 9∐U <i>n</i> kno	ant at time of wn	death 5	Other (spe	ecify)					NOTICE	Jay Toal
Δ.	The law requires that the deate has been signed by the bage 2 should be detached	Ph	Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco us	e contribute	to the cause of death?
Records,	uires tha signed Id be de	d b	Chronic Renal			, and the second						Yes 2□		Probably 4 🗷 Unknown
00	w requir	Completed									24a. Was	an	24b. Were	autopsy findings available
	The lay	ошо									autor perfo	osy rmed?	prior t death	o completion of cause of ?
Vital		Be C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗀 Y	es 2 No
\	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2🏝 No	Hospital: 1 🗶 I	npatient 2[☐ ER/Outpatier	nt 3 🗆 DO	A Othe	00		me 5□ Resi		□Other (Si	pecify)
Division of	ding f		27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time o Injury	M 21	8c. Injury Work	rat ⟨? Yes 2 □ I		28d. Describe I	how injury	occurred	
ĎĬŸį	Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildir	of Injury - At I	home, farm, str ify)	eet, factory	, office		2	28f. Location (: City or To		Number or	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical	29a. Certifier (Crisck only one) 2 Medical Example one)	iner: On the ba	SIS OF BARRITIC	nowledge, death	h occurred a	at the tim	e, date an	d place, a	and due to the	cause(s) a	nd manner place, and d	as stated. ue to the cause(s)
	o the ithin 2 o the implei	Med	29b. Signature and title of certifier.	and manr	er stated.		-		number					onth, Day, Year)
	F ≯ F 8			nmi	\triangleright				0616	,21				-05
	3		30. Name and address of person who of			m 23a) (Type								
			Natasha Chen, M.I				,	oad,	Beth	esda	, MD 2	20814		
	Sta		31. Date filed (Month_Day, Year)	105 32 A	egistrar's Sign	nature (will							
	Registr	ar	005 10 20	R.M.	MINE I	La Parle								

			1 - For State Registrar	State of Ma	aryland			nt of He te of E		and Me		giene Reg. No.	Z U []	5	243	326
			Decedent's Name (First, Middle, Last)					-			2. Date of De		•		3. Time of	
	Physici		ELIZABETH M. WIL	J.EY							Month	Day 13		ear	100	21 M
	/Medio		4a. Facility Name (If not institution, give st		_		4b. City,	Town, or	Location of	f Death	sury		County of			
			EASTON MEMO	MIGL A	405P	itAL		EA	Stor	U		-	TAL	-60	1	
	Funeral		5. Social Security Number 6. Sex			ast birthday)	If Unde Months	r 1 Year Days	If Under 2		B. Date of Birt	h Vear	9.	Birthpl Count	ace (State	or Foreign
0	Director		213-12-6254	м 200 г	81	Yrs.	MOUNTS	Days	riouis	(VIII).	B. Date of Bird (Month, Da IAN 21,	192	24 M	RYL		
put	3:::::		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	oation							10	a lasida O	
lanyla	sho	ö	MD TALBOT	,	100. 01.		EASTO	N						10	d. Inside C	•
the M	28a-f	Director	10e. Street and Number	•				Code				10- 0%	zen of Wha			
death with the Maryland	P O		704 N. WASHINGTON	CT			101. 21		CO1			rog. Citi			ry?	
eath	ns 23	era		2. Was Decedent I	Ever in LLS	3 13 1	Was Dece	216		nin? /Snec	ify Ves or No		14. Race -		n Indian	
ē	nd Mental Hyglene marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examinat must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 21 N If Yes, Give Year or Dates:			f Yes, spe		Specify:	, Puerto R	ify Yes or No ican, etc.)	1	Black, Specify: V	White, e	tc.	
215-0036 ithin 72 hours af	sal E	ed	15. Decedent's Educ	ation	1	16a. Deced	dent's Usu	al Occupa	tion				nd of Busin			
1215 -within 72	We di	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	54\	(Give life. L	kind of wo DO NOT u	ork done di ise retired)	uring most	of working	7				,	
₹ →	giene.	E	12	0	,+)	TOV	N CL	ERK				TOV	N OF	EAS	TON	
ind 2	other vent.	Be C	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (First, Middle,			112.00	2011	
Maryland d 2 should be file	Mental arked o atic eve	TOE	CARLTON L. PARDOE							MARI	E SATO	HELI				
2 sho	g # 5		19a. Informant's Name/Relationship (Typ								Route Numbe		r Town, Sta	te, Zip (Code)	
	or Health and Mer Item 27 is marke other treumatic		ROBERT C. WILLEY/S	ON					EAS.	TON,	MD 216	01				
more	in the		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Pla	ace of Disponentery, cren	sition (Name matory or o	me of other place)	Da	te	20c. Lo	cation - Cit	y or Tov	vn, State	
Fag Fag	ment: lury o		' 4 ☐ Donation 5 ☐ Other (Specify)		WOO	DLAWN	MEMO	RIAL	PARK	7/18	/2005	EAS	TON,	MAR	YLAND	
Baltimore, permit. Pages 1 ar	Department of Importent: If It any injury or o		21. Signature of Funeral Service License			FE	LLLOW	S HE	of Facility	BEIN	& NEWN	AM F	UNERA	т. н	OME P	A
	J = @ Cl			FRLEA							& NEWN EASTON		2160	-		
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	ysician /ledical	3 1	Immediate Cause (Final disease or condition resulting in death)			رو د او	20	Hea	~t	Fa.	100	e		1		
	aminer			Due to (or as	,		,	J~								
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uted	ansit	Examiner	if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events													
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	ngph ast	0	IE CENALE													
. Box 6	attending I for use as	an/h	200. Was decedent program	lc. If yes, outcome 1 ☐ Live birth			Ectopic p	recnancy				2	3d. Date of			
	he ati ed fo	sici	in the past 12 months? 1 Yes 2 No	4□Pregnant at 9□ Unknown			Other (sp						Month		Day Y	'ear
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S the state of the			Part II. Other significant conditions control	ributing to death bu	ut not resul		1						se contribu			
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e ec	2 5	nple	Disense								24a. Was autop	SV	prior	to com	sy findings a	available ause of
	pag	Con									1 Yes	med? 2√No	deat	h? Yes 2	NO	
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Physi	this cral dire	2	10105 2500	spital: 1 Shipatie		R/Outpatient		The Control of	4 [] (AUI:	-	5 Resid			Specity)		
Ing F	fter	no	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	ry y Year)	28b. Time of Injury		28c. Injury : Work?	?		d. Describe h	ow injury	occurred /			
Sicol	ctor: A y the fu	icat	2 Accident Investigation 3 Suicide 6 Could not be	00 01 111			M		es 2 □ N						_	
DIVISION For Attending	0 0	Certification	4 Homicide determined	28e. Place of Inju building, etc			eet, ractory	, office		28	f. Location (S City or Tow			r Hurai i	Houte Numi	ber,
Hospital or Attending	illed		29a. Certifier Certifying Physic	cian: To the best o	of my know	vledne death	Occurred	at the time	data and	I place, an	d due to the	20100/0	and mann	s ac atal	and .	
e Hos	24 nours and Funerel Dir letely filled in	Medical	(Check only 2 Medical Examine one)	er: On the basis of and manner sta	өхалипаци	on and/or inv	estigation	, in my opi	nion, death	n occurred	at the time, o	date and	place, and	due to t	he cause(s)	1
To the	To the complet	Me	29b. Signature and title of certifier				290	c. License	number			29d. Date	signed (M	onth, D	ay, Year)	
			Day F.	Je - I	2	Pol	(200	531	01	-	Sulv	13	7	005	
(,		30. Name and address of person who com	npleted cause of de	eath (Item :	23a) (Type, F	Print)		- / 1)	
(5)			DENNIS M. DESHIELI	OS M.D. 2	219 S.	WASH	INGTO	ON ST	. EAS	TON,	MARYL	AND :	21601			
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 1 5 2005	37 Registra	ar's Signatu	re A									_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Cortificate of Death

			For State Registrar	State of Ma	aryland			t of He		d Menta		ene	0 200	2
	Physici /Medic		Decedent's Name (First, Middle, Last) KENNETH ALOIS We	OLF						2. Dat Mo Ju	e of Death nth	Day	U 5 005	2 Time or Death 7
	Examir Funeral		4a. Facility Name (If not institution, give s Genesis HealthC 5. Social Security Number 6. Sex	are - Th	(In yrs. la	ast birthday)		Eas	ton If Under 24 H	Irs. 8. Dat	e of Birth	Year)	9. Birthp	place (State or Foreign
	Director Mount	<u>.</u>	214-14-7913 Usual Residence of Decedent 10a. State 10b. County		,	Yrs.	ocation			001			PA 1	10d. Inside City Limits
	d within 72 hours after death with the Maryland Jiene rthan "naturel", or Items 23a or 28a-1 show The Medical Examener must be motified at	Funeral Director	MD TALBO 10e. Street and Number 700 PORT ST. 11. Marital Status 1	2. Was Decedent B		ASTON S. 13.	10f. Zip	216	601 panic Origin? Mexican, Pu	(Specify Ye			A. Americ	ntry?
12-0036	72 hours after on naturel; or iter	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	Armed Forces? 1 M Yes 2 N If Yes, Give Year or Dates: ation completed)	lo	16a. Dece	1 Yes	2 No al Occupations done dui	Specify:			Specify: 6b. Kind of Bu	1.00	HITE
Z17 D	Hyg the	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	life.	DO NOT u	SUPE	RINTEN 8. Mother's N	DENT	Middle, M	CHEMICA laiden Sumam		OMPANY
, maryian	s 1 and 2 should be f Health and Mental item 27 is marked o other treumetic eve	To	SHERIDAN WOLF 19a. Informant's Name/Relationship (Tyx JAMES K. WOLF/SON				35		d Number or		Number,	GER City or Town, MARYLA		•
altimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 \(\frac{\text{M}}{\text{Cremation}} \) Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses		C	2	KE CR	EMATI Od Address	ON CTR		/2005		ENSV	ILLE, MD
ng R	permit. Departrimporte any injuly		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final	cations that caused e cause on each lin	the death	\mathcal{L} $\begin{bmatrix} \mathbf{F} \\ 2 \end{bmatrix}$	ELLOW 00 S. ter the mod	S, HE HARR	LFENBE ISON S				RAL I	Approximate Interval Between Onset and Death
8/60,	Physician /Medical Examiner physician and the prizel-transit the prizel-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a consequ	uence of):								monu
O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s)					23d. Date Mor		ery Day Year
Hecords, P.	aw requires s been sign s should be	Completed by Ph	Part II. Other significant conditions you Urinary black Abdominal	tributing to death be	ut not resu	ulting in the u	inderlying (cause given	in Part I.	-		s 2 □ No	3 Prot	he cause of death? bably 4 Unknown posy findings available impletion of cause of
Vital Re	ician: The la certificate ha rector, page ?	Be Com	25. Was case referred to medical			J			26. Place of [perform Yes 2	IBO? d	eath?	
ō	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To	1 Yes 2 No H	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatie 28b. Time o Injury		28c. Injury a Work?	4 Nursini			nce 6 Othe w injury occurre		(y)
Division	pitel or Atte burs after de erel Directo filled in by th	il Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	c. (Specify	()			date and ni	Cit	y or Town,	State)		al Route Number,
		Medical	(check only one) 2 Medical Examir 29b. Signature and title of certifier	Present To the basis of and manner sta	examina	tion and/or in	vestigation	c. License	nion, death o	ccurred at th	ne time, da	te and place, a	and due to	Day, Year)
(0,41/18		30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type	Print)	NANG	s LANG	i E	AST	ón M	D	21601
		ate rar	31. Date filed (Month, Day, Yegul 1	4 2065 gistra	ar's ggna	ture	*	Right	12)		

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			jiene leg. No. 2 N	0.0	0 1 0	
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	th	U 0	5Time of	Death 0
	Physici		Joseph Dale Wils	son				July 8	Day 2005	Year	8:28	рм
}	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat		4c. County	of Death	0.20	
			Holy Cross Hosp	ital		Silver	Spring		Mor	ntgome	ery	
	Funeral		Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp	lace (State or	Foreign
	Director		219-01-7820	∑X M 2□ F	86 Yrs.	Months Days	Hours Will.	May 4,	1919		yland	
	pu		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				1	0d. Inside Cit	u Limita
	sho	ŭ			•					'	1 ☐ Yes	
	tha M	Director	Maryland Mor	ntgomery	SIL	ver Sprin	g		I0g. Citizen of \	A/h a A Causa		
	with Ba or		9209 Bradford I	Road		20901			log. Oilizbii oi	USA	itiy:	
	ba filed within 72 hours after death with the Maryland tal Hygiene. Id other than "neturel", or items 23a or 28a-f show event, the Medical Evantrat must be notified at	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Rac	æ - Am <i>e</i> ric	an Indian.	
"	r iten	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯	No	If Yes, specify Cuba	ın, Məxican, Puər	to Rican, etc.)	Blac	ck, White,	etc.	
93	elt, o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify	White	9	
2-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra			dent's Usual Occup- kind of work done		rkina	16b. Kind of B	usiness/Inc	dustry	
2	within ene. than	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired	j)	g				
7	a filed w Il Hygier othar th		12		C1	erk	40.14.14.14.14	4000	U.S. G		nment	
and and	ba fil ntal H ad otl	Be	17. Father's Name (First, Middle, Last) Cecil Dale Wilso					m <i>e (First, Middle, .</i> Lee Nel		10)		
ž	2 should ba to and Mental I is marked of eumatic eve	2	19a. Informant's Name/Relationship (10h Maili	ng Address (Street a				04-4- 7-	0-4-1	
, Maryland 21215-0036	es 1 and 2 should b of Health and Ments if item 27 is marked ir other treumatic e		Leta B. Wilson/ W			Bradford						
ore	of He of He fitem	1 1	20a. Method of Disposition 1	Domougl from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac		1 ** 10	20c. Location -	City or To	wn, State	
Ĕ	nit. Pag artment ortent: I injury o		'4 □Donation 5 □ Other (Specify			even Cemete	ry 2	005	ilver S			
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Sign y re y Funeral Service Licer	L Cole	£ 50	R Name and Address rancis J. 00 Univer	s of Facility. Collins sity Blv	Funeral	Home I	nc prinç	g,Maryl	and
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	cations that caused e cause on each li	the death. Do not ent	er the mode of dyin	g, such as cardia	or respiratory arr	est,		Approximate Interval Betw	
	Pnysician	0.1	Immediate Cause (Final disease or condition	Coronar	y Artery D	isease					Onset and De	ath .
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
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	ad sit	Examine	cause. Enter Underlying Cause (Disease or injury	Day to for as	a consuluence or							
	xecul and al-tra	хаг	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					-		
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68	ificate g phy as the	edic		. u.								
Вох	death certifica attending ph d for use as tl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Tr-4:			23d. Dai	te of delive	ry	
-	ne deatl the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Ectopic pregnancy Other (specify)			Мо	nth	Day Ye	ear
P.0		hys	9 🗆 Unknown				Will the same					
	se gu	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		bacco use cont			
brd	w requir been si should	ted						1 🗆 Ye	9s 2 No	3 Proba	ably 4 ∐Ur	iknown
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E	Th ate pag	Con						perform 1 ☐ Yes	med? Y⊡ No 1	death? I 🗌 Yes	2□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ith (Check only on				
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on	ding h. After fune	tlon	1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	Year) Injury	Work	(? Yes 2 ☐ No	200. Describe III	ow injury occurr	50		
Division	Attending r death. sctor: After	fica	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home, farm, str			28f. Location (St	reet and Numb	er or Rura	Route Numb	er,
ă	s after s after al Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)			City or Town	n, State)			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	of my knowledge, deatl examination and/or in ited.	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)	
	To the Vilhin 2.	Me	29b. Signature and title of certifier		4.5	29c. License			9d. Date signed	1 (Month, L	Day, Year)	
	20		· anolyn	your.	MI	DS	846		JULY	8, 4	2005	
			30. Name and address of person who Carolyn J. Sporr	completed cause of d	eath (Item 23a) (Type, 500 Forest		d, Silve	r Spring	, MD 20	901		
	Sta	te.	21 Date filed (Month Day Veer)	20 Pagists	nda Cignoturo			1 9				7
	Registr	- 1	JUL 12 21	005 Bear	J. J. Ap	mes!						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 15

Amend Item 28a per ME, G852 Of 102 106 Ghb

Reg. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year heeler **Physician** 2001 0100 Tuly /Medical 4c. County of Death Name (If not institution, give street and number 4h City, Tewn, or Location of Death Examiner NON Appolio rundel (JUN) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 27 F 176-18-8320 8 1 Yrs. 4 1924 S. Carolina Dec Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State works rel', or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Annapolis Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 1912 F Copeland St. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2☐ Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Marvland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I othar than " Elementary/Secondary (0-12) 8th College (1-4or 5+) Factory Worker Burkarts Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 is marked ott Be Lillian McCode James Wheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1912 F Copeland St. Annapolis, Md. 21401 Florence Ralls(Daughter) Department of Health a Importent: if item 27 is eny injury or other traignts. Date 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 7-12-05 Baltimore, Md. Metro Crematory * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry B. Kless MOGY8 821 West St. Annapolis, Md. 21401 ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Hypertensive atherosclerotic cardiovascular disease 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause an each resquence of): complicating hyperthermia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner APPROVED BY MEDICAL EXAMPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine anding physician and use as the burial-transit certificate be executed CERTIFICATION Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter Month Day ō in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No this 28b. Time of unk 28c. Injury at Work? 28d. Describe how injury occurred Exposed to high 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death Certification: 5 Pending 1 ☐ Yes XX No environmental temperature death. 2 Accident investigation July 67 2005 after death 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1912 Cope land St 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Annapolis, MD House within 24 hours a To the Funaral C To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29d. Date signed, (Month, Day, Year) 29c License number 29b. Signature and title of certifier COUY 00060 cause of death (Item 23a) (Type, Print) BNYS, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State	of Maryla		artmen rtificat			and M	_	giene Reg. No	00	15	21 220
	Physici	an	Decedent's Name (Fire	rst, Middle,	Last)							2. Date of De Month	Da	<u> </u>	ear	3 Time of Death
	/Medi	cal	Madge 4a. Facility Name (If not	inctitution	airo stroot and a	Whitne	ey	4h Cih	Town or	Location of	of Dooth	July 7		. County of	Dooth	4:55PM ^M
1	Examir	ner	13340 Harr							Anne				Somer		
	Funeral		5. Social Security Number		3. Sex	T -	s. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir				ace (State or Foreign
L	Director		214-42- 99 Usual Residence of Dec		1□M aXF	92	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 05/06/	1913	M	aryl	ace (State or Foreign try) and
	ryland show			o. County		10c. C	City, Town or Lo	cation		<u> </u>					10	Od. Inside City Limits
	8a-1 s	octo		omers	et		Prince									1 ☐ Yes 2 🗷 No
	with ti	듬	10e. Street and Number					10f. Zip		F 0			10g. Ci	tizen of Wha	at Count	ry?
	leath ns 23	eral	13340 Harr	ison			U.S. 13.	Was Dece	218		gin? (Sp	ecify Yes or No)-	USA 14. Race -	America	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show may injury or other traumatic event, the Medical Examinar must be rediffied at once.	by Funeral Director	1 Never Married	_	Armed F d 1 Tes If Yes, G Year or	cedent Ever in corces? 2 No nive Dates:		f Yes, spe 1 ☐ Yes		n, Mexicar Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black,	White, 6	otc.
5-0036	2 hou	ted	15.	Decedent's	Education		16a. Dece	dent's Usu	al Occupa	ition			16b. K	(ind of Busin		
2121	thin 7 e. en "r	Completed	Elementary/Secondar		grade completed College	(1-4or 5+)	life.	DO NOT u	rk done d se retired	luring mos)	t of work	ng				
21	filed within 7 Hygiene. other then "r ant, the Med	Co	12		2		Licen	sed F	ract					ical		
Maryland	ld be fi ental H ked ot Ic evar	To Be	17. Father's Name (First Charles Col		as <i>t)</i>							e (First, Middle opkins	, Maider	1 Sumame)		
ary	2 shou and M is mar	-	19a. Informant's Name/	Relationshi					(Street a	ind Numbe	or or Rura	- al Route Numb				
	and 2 lealth m 27 I		Carolyn W.		e11/daug					Land						ne,MD 21853
Baltimore,	Pages 1 nent of H int: if ita		20a. Method of Dispositi Burial 2 Cr 4 Donation 5	emation 3	3 □Removal from	State	Place of Dispo cemetery, crei bury U.	natory or o	ther place			Date / 2005		ocation - Cit it Ver	-	
3alti	permit. Departn Imports any inju		21 Signature of Funera	Serios ki	ensee		Hi	Name ar	d Addres	s of Facilit	ome					
ш	20 E 8 9		WINWO	ZH	KNIX	M0029	95 11	673 S	omer	set A	ve.,	Princ	ess_	Anne,	MD	
	Physician		23a. Part1. Enter the di shock, or heart fail Immediate Cause (Fina disease or condition		omplications mat	each line.	ath. Do not ent	er the mod	le of dying	g, such as	cardiac (or respiratory a	rrest,			Approximate Interval Between Onset and Death
	/Medical Examiner	,	resulting in death)	- 1	Due to	(or as a conse	equence of):	0		•	200	ieare				
30,		i Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last	ons, diate g	c	o (or as a conse		~ V	-11111	C	V13					
68760,	ficate t	edicai		738	d											
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent preinthe past 12 mon 1 ☐ Yes 2 No 9 ☐ Unknown	the?	1 Live	utcome of pregi birth 2 - Fe gnant at time of nown	tal death 3	Ectopic pi Other (sp						23d. Date o Month		y Day Year
Ω.,	quires that on signed by uld be deta	b	Part II. Other significan	t condition	s contributing to	death but not re	esulting in the u	nderlying o	ause give	en in Part I.			obacco Yes 2		ite to the	e cause of death?
Records,	ysician: The law requir is certificate has been si director, page 2 should	Completed	-							-	_	24a. Was auto perfo		prio dea	r to com th?	sy findings available pletion of cause of
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to examiner?	o medical						26. Place	of Death	(Check only	-0	, , , ,		
of Vital	Physician: this certific ral director,	²	1 ☐ Yes 2 No				☐ ER/Outpatier			4 🗀 Nu	rsing Ho	me 5 Resi	dence	6 Other	Specify,)
ou c	ding Phi h. After thi funeral	lon:		☐ Pending	(Mo	e of Injury nth, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	how inju	ry occurred		
Division	Attanding r death. actor: After by the fune	ficat		investiga Could no	t be	ce of Injury - At	home farm str	M eet factor		res 2 □		28f Location (Street au	nd Number	or Rural	Route Number,
Ō	s after in Dira	Certification:	4 🗌 Homicide	determin	buil	ding, etc. (Spec	cify)	001, 120101	, 011100			City or To	wn, State	9)	<i>31 1 10101</i>	riodio ridinosi,
	To the Hospital or Attanding I within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	Medical (29a. Certifier 1. (Check only one)	Certifying Medical E	Physician: To the xaminer: On the and ma	ne best of my kr basis of examir nner stated.	nowledge, deat nation and/or in	n occurred vestigation	at the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date an) and manne d place, and	er as sta	ited. the cause(s)
	To the within To the comp	W	29b. Signature and title	of entifier	01	200		290	. License	number			29d. Da	ite signed (A	Aonth, E	Pay, Year)
			700	100	1' hy	71 Celo			45	724	1/4	nD	C	7/08	5(0	5
_			J.C. Patron	MEZ	no completed car	820 Ju	eet Ben		1,5	intel	10	Salisha	7	ND 21	800	1
	Sta Regist	ate rar	31. Date filed (Month, D		2 2005	Registrar's Sign	nature	da.								

			For State Registrar	State	of Maryland		artment of F		d Mental Hy	giene Reg. No	005	2433	3
			1. Decedent's Name (First, Midd	le, Last)			-		2. Date of D			3. Time of D	eath
	Physici /Medic		Janet P. West						July	10	2005	4:54	P^{M}
	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o	r Location of D	Death	4c.	. County of Death		
7		*:	Union Hospital	of Cecil	County		E1kton				Cecil		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. In 67		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi (Month, D Nov • 28	irth a <i>y</i> , Yea <i>r)</i>	9. Birth Cou 7 Delay	place (State or I	Foreign
	Director		221 22 4948 Usual Residence of Decedent		07			1	NOV - 20	, 193	/ рета	wale	
	yland 10w		10a. State 10b. Count	/	10c. City	, Town or Lo	cation					10d. Inside City	Limits
	Mar B-f st	tor	Delaware New_C	astle	Mid	dletov	m					1 ☐ Yes 2	No No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	intry?	
	23a		121 Redden Lan	е			19709			Un	ited Sta		
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23a or 28e-f show event, I're Medical Enatified remains the notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 🛣 Widowed 4 □ Divorce	Armed F	2.∰No ive	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🗓 No	an, Mexican, P	? (Specify Yes or N Juerto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: W		
Š	2 hou ature			nt's Education	.	16a. Dece	dent's Usual Occup	ation	(dia	16b. K	(ind of Business/Ir	ndustry	
215	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work done DO NOT use retire	during most of d)	working				
21	filed within Hygiene. ither then "	Son	12			Clerk	ζ			Foo			
nd	be file	Be (17. Father's Name (First, Middle						Name (First, Middle		Sumame)		
Maryland 21215-0036	nd 2 should be lith and Menta 27 is marked r treumetic ev	ပ	Stonewall Jack		У				nce Murra				
Var			19a. Informant's Name/Relation				•		or Rural Route Numi	-		p Code)	
	1 a/ Hea Hea the		Janice Burns/D	aughter	20b. P	lace of Dispo	sition (Name of		wnsend, De	_	re 19/34 ocation - City or T	own. State	
Baltimore,			1X Burial 2 ☐ Cremation		State De Î	emetery, crei .aware	natory or other plac Veterans	Ju	ly 14, 005		r.Delawa:		
薑			'4 □Donation 5 □Other (Mem		Cemetery		Crouch F	_		Le	
Ba	permit. Departr Importa any inji		full to						treet,Nor			land 219	901
	•		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause on	caused the death	. Do not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	aau	Je NI							Onset and De	ath
	/Medical Examiner		resulting in death)		(or as a consequ	uence of):			11 11 11 11 11 11 11 11 11 11 11 11 11			-	
	Lammer	<u>.</u>	Sequentially list conditions,	b. — Due to	(or as a consequ	ience of):						·	
	bed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	(OI as a consequ	derice ory.							
	xecul al-trai	xan	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):							
8760,	cate be executed physician and the burial-transit	dlcal											
687	ificate g phy as the	edlo											
O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Fetal mant at time of de nown	death 3[Ectopic pregnanc Other (specify)	y			23d. Date of deliv Month	rery Day Ye	ar
Д	that I	by Ph	Part II. Other significant condit	ions contributing to	death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of dea	ith?
Records,	w requires been sign should be		IDDH						1□	Yes 2	□No 3□Pro	bably 4 Uni	known
00	aw requ s been s shoul	Completed	CHF						24a. Wa		24b. Were aut	opsy findings av	ailable
R	The lav	mo							peri 1 ☐ Yes	opsy formed? 2 12 No	death?	ompletion of cau No	S0 01
Vital		Be C	25. Was case referred to medic	al			-4-8	26. Place of	Death (Check only				
f V	dilb	70	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Ott	ner: 4 ☐ Nursi	ng Home 5 ☐ Res	sidence	6 ☐Other (Speci	ify)	
n of			27. Manner of Death 1 ☐ Matural 5 ☐ Pend	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o Injury	Wo		28d. Describe	how inju	ry occurred		
Sio	Attending r death. ector: After by the fune	cati		tigation				Yes 2 □ No		(044-		-1 O-1-1-11	
Division	is Diriginal	Certification:	4 Homicide deter	mined 289. Plat	e of Injury - At ho ding, etc. (Specify	me, farm, sti /)	eet, factory, office		City or To	own, State	nd Number or Rur e)	ai Houte Numbe	er,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in It	edical Ce	29a. Certifier 1 🛣 Certify (Check only one)	ing Physician: To the Examiner: On the and ma	ne best of my kno basis of examinat	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time	e cause(s	and manner as did place, and due to	stated. to the cause(s)	
	Fo thi within Fo the	Me	29b. Signature and title of certifi			_	29c. Licens	se number		29d. Da	ate signed (Month,	Dey, Year)	
	> - 0		> Khiha	6			7	2062	643		7/10/0	5	
	10		30. Name and ddres of perso	n who completed car	use of death (Item	23a) (Type,	- 1 /				1,5/0		
	10		K. Lefr	ak 106 B	ow Stree	et,E1k	ton,Maryl	and 21	921				
	Sta		31. Date filed (Month, Day, Pea JUL 12 2005	r) 0 32.	Registrar's Signa	ture							
	Regist	rar	JUL 1 2 2005	Bleen	K A	2000							

, NORMAN

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day BLACKWELL コロノッ 3 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NA The Johns 4057101 Boltimare HODKINS CIT If Under 1 Year If Under 24 Hrs Months Days Hours Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country)
 Md . **Funeral** Days 1□ M 2X F 72 213-30-6007 Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1XYes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1224 N. Patterson Park Ave. 21213 USA or Items 23g death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify 3₹ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry School 5 4 1 Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Teacher Asst. Baltimore City Public 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred 2 Mollie Dickerson, Sr. Holiday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 la any injury or other traconce. Steven Blackwell Son 3810 Southern Ave., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Greenmount Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 7-27-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Warren las March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician type tension to (or as a consequence of): disease or condition resulting in death) /Medical Examiner cell Sequentially list conditions, if any, leading to immediate cause. Entar III certying Concer Examine Due to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events anding physician an use as the burial-tr resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2□ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 ER/Outpatient Inpatient 3 DOA 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Injury at Work? 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deat 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Des 000 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21205 D S1. Date filed (Month, Day, Year) 600 N. wolfe NWavery Boltimore Johns Hapkins HOSPITAL 32. Resstrar's Signature State JUL 26 2005 Registrar

-		For State	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygie	ne
	No.	Registrar 1. Decedent's Name (First, Middle, Las		erinicale of Dealif	Reg. 2. Date of Death	2003 G time of Death
Physici /Medi		CHERYL	BROADNAX		July 17	2005 Year 4:20 P
Examir	ner	4a. Facility Name (If not institution, give Johns Hopkins Hos		4b. City, Town, or Location of Dea	th	4c. County of Death
Funeral Director		5. Social Security Number 6. Se		Months Days Hours Min		9. Birthplace (State or Foreign 1959 MARYLAND
land wo		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limit
e Mary e-f sh	ctor	MD	BA	TIMOKE		1 1 Yes 2 □ N
with the a or 28	Director	10e. Street and Number	EPER St.	10f. Zip Code 2124	10g.	Citizen of What Country?
death me 23	Funeral I	11. Marital Status		Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28e-f show any Injury or other traumatic event, the Medical Examinat roust be notified at ance.	ρ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forcess 1 ☐ Yes 2 ☐ No 1f Yes, Give Year or Dates:	If Yes, specify Guban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	rto Rican, etc.)	Black, White, etc. Specify: BLACK
n 72 h "natu	Completed	15. Decedent's Ed (Specify only highest grad		icedent's Usual Occupation ive kind of work done during most of wo	orking 16b	. Kind of Business/Industry
d withing giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	SUPERVISOR		1. KONE PRICE
d 2 should be file to and Mental Hy. It and Mental Hy. It is marked other traumatic event,	Be	17. Father's Name (First, Middle, Last)	run, SR.	18. Mother's Na	me (First, Middle, Maid	ten Surname)
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and 2 and 2 alth ar 127 ts		GREGORY L. BROM	(-)	ON. STREEPER St.		E, MARYLAND 21205
permit. Pages 1 a Department of He Important: If Item any Injury or othe		20a. Method of Disposition 1 M Burial 2 Cremation 3	Removal from State cemetery, o	sposition (Name of crematory or other place)	1	Location - City or Town, State
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Depariment Impo	6	I Signature of Furieral Service Licent	fren !			MORE, NO 21212
e 8		23a. Part1. Enter the disease, o comp shock, or heart failure. List only	olications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Multine 1	insuries		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
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The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
hat the dead by the a	ysici	1 ☐ Yes 2 ☐ No	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month Day Year
s that I	by Ph	Part II. Other significant conditions co	ontributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
I or Attending Physicien: The law requires teles to effect death. Director: After this certificate has been signed in by the funeral director, page 2 should be					1 ☐ Yes	2 No 3 Probably 4 Unknow
2 8 8	Completed				24a. Was an autopsy	24b. Were autopsy findings availab
in: Th ificate or, pag	e Col	25. Was case referred to medical		20 21 / 2	performed 1 Nes 2 □	
Physicien: r this certificanal rail director.	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ¬ER/Outpat	Other	eath <i>Check only one)</i> Home 5 🗆 Residence	3 6 □Other (Specify) 5 □
ing Ph Viter th uneral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury at Work?	28d. Describe how i	
death ctor: /	licati	2 Accident investigation 3 Suicide 6 Could not be	102110	Hours 1 Yes 2 No	28t Location (Stree	t and Number or Rural Route Number,
s efter	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	Littl	City or Town, S	tate) Ethen + Medyan Ma
To the Hospitel or Attending Physicien: The within 24 hours efter death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edicai (Check only 2 Medical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or	eath occurred at the time, date and place	e, and due to the causeurred at the time, date	e(s) and manner as stated.
thin 24 thin 24 the F	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
F 3 F 8		1-100	11 7:	OCME		Ly 18, 2005
		30. Name and address of person who	completed cause of dea(h (Item 23a) (Typ		Jul	_y 10, 200)
		THEODORE M.		111 Penn Street	, Baltimore	e, Maryland 21201
St. Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar's Signature			

DHMH 17 Rev 1/2001

"neture!', or iteme 23a or 28a-f show idical Examiner must be notified at Baltimore, Maryland 21215-0036 **Un Madical** al Hygiene. traumatic event, Mental marked t and 2 should be Health and Ment Fet permit. Pages 1
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Physician

/Medical

Examiner

Director

Funeral

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Physician /Medical Examiner

be executed attending physicien and for use as the burial-transit the esn nse signed by the a d be detached for has

o Records, this certificate Vital director, ot al or Attending F s after death. After on Director: filled in by within 24 hours a To the Funeral C Hospital completely

RISCOE

Examine Iclan/Medica Phys Š Completed P Certification:

cal

State Registrar

I. Decedent's Name (First, Middle, Last) SHIRLEY 4a. Facility Name (If not institution, give street and number) ST. AGNES 5. Social Security Number 216.32.2637 Usual Residence of Decedent 10a. State MD 10e, Street and Number 2102 11. Marital Status 1 Never Married 2 Marned 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE 17. Father's Name (First, Middle, Last) JAMES MEADS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2702 KEYWORTH AVE. # 201, BALTO. MD 21215 (HUSBAND) HAROLD BRISCOE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01.28.05 GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MIUS, MD 21. Signal re of Function Service Licensee 22 Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE large 5151 BALTO. NATE PIKE, BALTO- MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EMPHYSEMA. Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 28 No

25. Was case referred to medical examiner' 1 Tes 2 No

6 Could not be determined

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

4 Homicide 29a. Cortifier (Check only

3 🗌 Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier SyOD MAKOOD MD.

29c. License number P16766

1x Confliging Physicians To the best of my knowledge, death promoted at the time, date and place, and due to the eaucote) and manner as stated

28c. Injury at Work?

1 Tes 2 No

26. Place of Death Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Approximate Interval Between Onset and Death

DAYS

YEARLS

YEARS

Day

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATONS AVENUE, BALTIMORE, MD, 21229. SYED O. MASOOD.

31. Date filed (Month, Day, Year)



Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 - 24336 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May N. Belt BOD DIM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Dec 9. Birthplace (State or Foreign County) Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 218-28-0430 1 M 2 F 75 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f ehow the Medical Examiner must be notified at Maryland Carroll 1 Yes 2 No **Funeral Director** Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1139 S. Main St. 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by White 3. Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, ODGs. traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melvin Bull 2 Mildred Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Belt - daughter 1139 S. Main St. Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens July 28,2005 Finksburg, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Chapel P.A. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WKS. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included and the cause of the cause Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? õ Day 4☐Pregnant at time of death 5 Other (specify) be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ZNO 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**.** No 1 Yes 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 📉 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 1 Atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (/ 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

NJM	3003		1 - For Unpend Item 23	state of Marylan a,27,28a-f	d/Depa	ctment of 1	dealth and	Mental Hy	/giene	3.2.0.		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	runcate of	Deam	2. Date of D		005	2133	7
	Physici	an	Jason Allen Brow	'in				July	Day 24	2005	1 01 1	atn;
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b City Town	or Location of Deatl			ounty of Death	1811	
-	Examili	er	5700 Kenwood Aven				edale					
0	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. /	ast birthday)	If Under 1 Year	If Under 24 Hrs.		irth	altimor	lace (State or Fo	oreign
9	Director		217-04-3979 ¹ X ^M	^{2□ F} 30	Yrs.	Months Days	Hours Min.	Feb. 1		Mari	iland	,
(A)	D *		Usual Residence of Decedent 10a. State 10b. County	100 Cin	, Town or Lo							
	ehov	5								1	0d. Inside City Li	
	the M	Director	Maryland Baltimore 10e. Street and Number		Вал	Etimore					1 Tes 2	X
	a or	급	5700 Kenwood Avenu	0		10f. Zip Code	206			of What Cour	itry?	
	leath	by Funeral	11 Marital Status 12	Was Decedent Ever in III	S 13			necify Ves or N		U.S.A.	an Indian	
(O	riter of lines	Fun	1 XNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo			Hispanic Origin? (S ean, Mexican, Puert	o Rican, etc.)		Black, White,	etc.	
93	ours a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🕱 No	Specify:		Sp	pecify:	Ihite	
5-0	72 hours after death with the Maryland hatural, or lieme 23a or 28a-f ehow dical Examinar mual be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. Dece	dent's Usual Occup	pation	kına	16b. Kind	of Business/Inc	dustry	
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/lanc	uld be fi fental h rked ot tic ever	To Be	James Allen Brow	п			18. Mother's Nam	t Mari				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, Ite Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, James A. Brown (Print) Kather)			and Number or Ru We, Balt				Code)	
5	f Hea		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of		Date		ion - City or To	wn, State	
Ę	Page ient o nt: if ry or		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)			natory or other plac Valley Me	em'l 7/2	3/2005	Timon	ium. Ma	ruland	
alti	mit.		21. Signature of Funeral Service Licensee		22	. Name and Addre	ess of Facility Sc	rimunek	Funer	al. Home	A	
ä	Departiment of the particular in the particular		Buina. le	alle.			r Rd., Bo			21236		
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Division of Vital Records, P.O. Box	that the death cer ed by the attendin detached for use	Icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	у		200	Month	Day Year	:
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ď.	w requires that been signed to should be det	by P	Part II. Other significant conditions contrib	uting to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death	n?
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of .	this o	۵	1 Yes 2 No Hosp	1 Inpatient 2 E	R/Outpatien	t 3□ DOA Oth	er: 4 ☐ Nursing H	ome 5 ☐ Resi	idence 6 🔀	Other (Specify	Scene	
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Sic	death death stor:	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 🕱 Could not be	7-24-05		F _	Yes 2 No	201 1	·			
) į	after Direction by	Certification:	4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	et, factory, office		City or To	wn, State)	5700 Kei	Route Number,	re.
	Hospital			Scene In: To the best of my know	uladaa daath	oncurred at the tra		partimo	re, Mo	l		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: one)	On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and pla	ce, and due to	the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. Licens	e number			gned (Month, I		
U			Jamet Forthall.	ul		00	ME		July	, 25, 2	005	
•			30. Name and address of person who compl									-
			tamela. E. Southall			treet, B	altimore,	MD 21	201			
	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 6 2005	22. Registrar's Signate	ure /	41 .						
The said	in Glotti		- or n 0 2000	ALLEN IS	A 12/24	and the same of th						

			1 _ State	partment of Health and Meertificate of Death		
	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 2640 Ashland Ave	4b. City, Town, or Location of Death Restricted Above		4c. County of Dealh
	Funeral Director		5. Social Security Number 6. Sex 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	e Maryland a-f show lifted at	ctor	10a. State 10b. County 10c. City, Town or BA			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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9800	72 hours after death with the Maryland naturel', or items 23a or 28a-1 show disal Examiner must be notified at	d by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F Yes 2 No Specify: 	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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	1 and 2 Health a em 27 ls ther trai		Kalhleen Bry mt Mc renty- northy 200. Method of Disposition 200. Place of Dis		e Bai	- 11 A h
Baltimore	permit. Pages Department of Importent: If it any injury or o		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	22. Name and Address of Facility Anthon C. Down KST	alas I	Salts County 1701 Mcallanst Vice P. A. RANO. MD2
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Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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Division of	r Attending er death. rector: Atte by the fune	Certification;	1	M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,
Ω	To the Hospitel or Attending Physiclen: whith 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Cer	29a. Certifier (Check only 2 Medical Evaminer: On the best of my knowledge, de-		nd due to the cause(s) and manner as stated.
)	To the within 2. To the complet	Me	29b. Signature and title of certifier / Cellur	29c. License number D (8327) B, Print) GO Wilter A	29d. D	ate signed (Month, Day, Year) July 26 (US
1	71		30. Name and address of person who completed cause of death (Item 23a) (Type Moges Gebremarian 40	a, Print) 660 Wilter &	for Be	et md 21225
	Sta Registr		31. Dale filed (Month, Day, Gear) 32. Registrar's Signature	pastes		

amend item#19b, perffh, 6845, 8/2/05 11 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle Last) 4:50PM NCENI **Physician** 2 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner apea If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MOV30, 19 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10 M 2□F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show any injury or other traumatic avent, the Madical Exp. in at count be notified at once. BelATY 1 ☐ Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If itam 27 Is marked other then "natural", or Items 23a or 7 USA Funeral 12. Was Decedent Ever in U.S. Armer Forces?

1 If Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cydan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) meer Merdell 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Tances Corge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19a, Informant's Name/Relationship (Type, Print) MD°21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20a. Method of Disposition 28 Burial 2 ☐ Cremation 3 ☐Removal from State 2005 4 ☐ Donation 5 ☐ Other (Specify) Ar Memoral Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Foreval chaper - Bel Arr Newport MD 21050 Forest Hill Approximate Interval Between Onset and Death 23a. Part! Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure hours Acute **Physician** /Medical Due to (or as a consequence of): **Examiner** days Stroke b. Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Pleural effusion with fluid overload weeks Division of Vital Records, P.O. Box 68760, ベ Due to (or as a consequence of) failure, biventricular years IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant I Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed h þ 3 Probably 4 Unknown 2 🗆 No Hypertensive nephropathy, End-Stage **Diractor:** After this certificate has been sin by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal disease on dialysis since 2001, bladder autopsy cancer metastatic prostatic

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 Yes cancer Boch, Vincent 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Magner of Death Certification: Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MX un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 105, Fallston, MD 21047 Hartord S. Sun, M.D. 1716 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 6 2005 Gosale Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year July 15 2005 9:20 Darlene Marie Bolger 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore City n/a Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2€ F Months 1954 Maryland 16, 213-62-9531 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 319 Stafford Dr. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 ☐No Yes. Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡ No Specify: white Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Clerk Medical Field 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Shirley Powell Charles Kilduff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9377 Lincoln Blvd. Apt. 2273 Los Angeles, C4 90045 Date Date 20c. Location - City or Town, State Jason Bolger- son 20b. Place of Disposition (Name of competery, crematory or other place Baltimore Crematory Loudon Park 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 16, 05 Baltimore City 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Loudon Park Funeral Home

Department of Important: If it any injury or o once.

Physician

/Medical

Examiner

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Funeral

Director

28a-f show

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Pages 1 and 2 s ment of Health an if Health if

Baltimore, Maryland

Director

Completed by Funeral

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traumatic event, the Medical Examiner must be notified at

other

Physician /Medical **Examiner**

Examiner

3620 Wilkens ave. Baltimore, Maryland 21229 angu caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. 23a. Pa.f. Enter the disease, or complications the shrick, or heart failure. List only one cause in Approximate Interval Between Onset and Death Immediate Cause (Final Metastati two years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy

attending physician and for use as the burial-transit The law requires that the death certificate be executed detached signed by Division of Vital Records, page 2 should be or Attending Physician: within 24 hours after death. To the Funeral Director: A filled in by the Hospital completely

2

27

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Certification: To

Medical

5. Was case referred to medical examiner?	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa
7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tim

evine

investigation

6 Could not be determined

tient e of (Month, Day Year)

3ET DOA Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Droched Home 28d. Describe how injury occurred

1 ☐ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

	(Check only one)	2 Medical Examiner	On the basis of examination and manner stated.	and/or investiga	ation, in my opinion, death occurred at the	me, date and place, and due to the cause(s)
9h	Signature and	title of certifier			29c. License number	29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause or death (Item 23a) (Type, Print) 1910 Farbank

Baktimore MI)

State Registrar

JUL 2 6 2005

32. Registrar's Signature Marie & Spark

			1 - For State Registrar	State o	f Marylan		artment of F				giene Reg. 20 ()5	24341
	\$ a.	10 m	1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
19	Physic		Ве	etty Jean	n M. C	ook				July 21		roai	6:22 P ^M
	/Medi Exami		4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death		4c. County	of Death	
			Jacob's Well	l Assisted	Living		Be1	Air			Ha	rford	[
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h Year)	9. Birth	place (State or Foreign intry)
п	Director		164-26-5928	1□M 2XF	73	3 Yrs.	Worth's Days	110013	(9)31.	MAY 4,	1932	Nev	rada
	D .		Usual Residence of Decedent		45.00	-							and to its Oits Limits
	inylar show	_	10a. State 10b. County	′	10c. Cir	y, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 X No
	ith the Marylan or 28e-f show se coulfied at	cto	Maryland Harf	ord			Bel	Air_					
	ift th	Oire	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	23£	E C	522 Thomas				210				USA		
	r deg	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U. orces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Amer ck, White	can Indian, , etc.
36	or i	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ※ Divorce	If Yes, Giv	ve		1 ☐ Yes 2 🔀 No	Specify:	-		Specif	y: W	hite
5-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show the Medical Examiner aust be positived at	De De		Year or D	ales.	16a Dece	dent's Usual Occup	ation			16b. Kind of 8	usiness/li	ndustry
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2121	withi ene. than	E	Elementary/Secondary (0-12)	College (1	1-4or 5+)	Medi	cal Techr	വിവം	ist.		Healt	hcare	2
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7	2 should I and Men is marke	1-	19a. Informant's Name/Relation			19b. Maili	ng Address (Street					State, Zi	o Code)
Z	and 2 ealth a n 27 is		Susan Dorsey	y/Daughte	er	1610	Wyclif.	fe A	venu	e Bal	timor	e, M	D 21234
ē,	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28e-1 show other treumatic event, the Medical Examiner must be publised at		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place	cel		ate	20c. Location	- City or T	own, State
Baltimore,	0 0		1 ☐ Burial 2 🖫 Cremation 4 ☐ Donation 5 ☐ Other (\$	3 Removal from	State		mation,]	1	7/22	2/05	Balt:	inore	MD
≣	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service		1100	22	2. Name and Addre	ss of Facili	ity				
B	Depar Impo any ir		Edward A.	Gregorchik		C	remation 99 Freder	Socie	ety o	f MD, I	nc.	2122	R
	4 +		23a. Part1. Enter the disease, o	r complications that of	caused the death	Do not ent	er the mode of dyin	ng, such as	cardiac	r respiratory ar	rest,		Approximate Interval Between
*	Physician .		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	ach line.	2	Walna	-500	2/2				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseg	Gence of):	y w w	0000	Ne				1 yeura
١.	Examiner				61	4/100	Mayo	L	6,0	5,2			Lyours
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events	S .									
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):							
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9	tifica ig ph as th	Physician/Medical											
ŏ	death certifica attending ph d for use as th	N/CI	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy	,				te of deliv	
œ.	deat e atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)				Mo	onth	Day Year
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o of			27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date (Mon	of Injury th, Day Year)	28b. Time or Injury	28c. Injur Wor	y at k?	1	28d. Describe h	ow injury occur	red	" Living
Ö	Attending ir death. ector: After by the fune	atlc	2 Accident invest	igation			M 1 🗆	Yes 2	No				
Division	l or Atteno after death Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace	of Injury - At ho ing, etc. (Specify	ome, farm, str	eet, factory, office			28f. Location (S City or Tow	treet and Numb n, State)	er or Rur	al Route Number,
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	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical	ng Physician: To the b	asis of examina	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, a th occurr	and due to the d ed at the time, d	ause(s) and ma date and place,	anner as a	stated. o the cause(s)
	the the mplet	Med	one) 29b. Signature and tyle of counting	and man	ner stated.		29c. Licens	e number		- 2	29d. Date signe	d (Month,	Day, Year)
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Ι.	()		31, Date filed (Month, Day, Year	11 DO. 38	egistrar's Signa	W7 60	770 LEU	er V	VIT		revuce	- 101	
	Sta Regista		JUL 2	ZUUD ZE	SELLES J.	55				/			

State of Maryland / Department of Health and Mental Hygien20051 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 940 AM William carroll ichard 07 3 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Norm west Randallstown HOSPITUL (enter Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1፟፟፟∭ M 2□ F 263-26-0602 Director 81 30, 1924 | Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23s or 28s-1 show other treumstic event, the Neulcal Example and other treumstic event, the Neulcal 1 ☐ Yes 2X No Director **Sykesville** Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7426 Village Road, Apt. 106 21784 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1945-51 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Construction Construction Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ပ William Charles Carroll Elizabeth Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 130 Spruce Street, #27B Philadelphia, PA 19106 John R. Carroll/Brother 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 <u>=</u> ö permit. Page Department. Important: If eny injury o * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/25/05 Baltimore, MD 21. Signature of Funeral Service Licensee

Edward A. Gregorchik 22. Name and Address of Facility
Cremation Society of MD. Inc.
299 Frederick koad Ealtimore. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aspiration disease or condition resulting in death) /Medical Due to kr as a consequence of) Examiner Chronic obstructive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by amal fibrillation wilmrapid ventular response 10 Yes 20 No Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2 1 ☐ Yes 2 ☐ No verel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3 DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Homicide ō 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only onel 29b. Signature and title of centriq 29c. License number 29d. Date signed (Month, Day, Year) 10 D00000000 30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) 750 Main street. Reisterraun, MD MICHELSON 31. Date filed (Month, Da 72. Registrar's Signature State 10000 Registrar

DHMH 17 Rev 1/2001

)	4	State of Registrar Amend Item State of Per F	Maryland / Depart H, G848, 10/26	artment of F 0/05dhb rtificate of	lealth and Death	Mental Hy	giene	~
Physicial /Medica	n	1. Decedent's Name (First, Middle, Last) R.	arter			2. Date of D Month JULY		25 2 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2
Examine	er	4a. Facility Name (If not institution, give street and numb 4320 CLAREWAY	er)	4b. City, Town, o	r Location of Dea MORE	th	4c. County of	of Death
, Funeral Director	2	5. Social Security Number 14-50-3624 Usual Residence of Decedent	Age (<u>In y</u> rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1947	9. Birthplace (State or Foreign
the Maryland 28s-1 show	ctor	10a. State 10b. County	Day t	ocation 7more	$\overline{\mathcal{O}}$			10d. Inside City Limits 1 Yes 2 □ No
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036 urs after des	٥	11. Marital Status 1 Never Married 2 Married 3 Widowed Divorced 12. Wis Deced 1 Yes 2 1 Yes 2 1 Yes, Give Year or Dat	ent Ever in U.S. 13. es? No	Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 ☐ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. Race Black Specify:	- American Indian, , White, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-1 show ent, tre Midical Examiner maste notities as	Completed	15. Decedent's Education (Specify only highest grade completed) Elementam Secondary (0-12) College (1-4	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Bus	
E da p ₹	To Be Co	17. Father's Name (First, Middle, Last) Melvin H. Carter		51000	18. Mother's Na	me (First, Middle	Maiden Surname	inGle.
and 2 should and 2 should beath and Mer m 27 is marks nor traumatic		tatrick E. Carter	231	7 Kate	and Number or R	Ct. A	bingd	State, Zip Code) MM 2/009
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Balt permit. Departi Importi any inj		21. Signature of Funeral Service Licensee	0	Jan Holden	JOCK	ele to	Eulto.	Services) MD 21212
	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	n line.	alysis	5 VOSC	ulac	graft	Approximate Interval Between Onset and Death
	Completed by Physician/Medical		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy			23d. Date Mon	of delivery th Day Year
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Division of Vital Re To the Hospitel or Attending Physicien: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: I	27. Manner of Death 1		f 28c. Injur Wor	4 - I I I I I I I I I I I I I I I I I I		how injury occurre	
Divisic To the Hospitel or Attant within 24 hours after deatt To the Funeral Director: completely filled in by the	Certification;		Injury - At home, farm, str , etc. (Specify)			City or To	wn, State)	r or Rural Route Number,
Hos n 24 ho ne Fune Metely I	edical	29a. Certifier (Check out) one) 1 Certifying Physician: To the b 2X Medical Examiner. On the bas and manne	is of examination and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	Sleh u	29c. Licens 0.C.	e number		29d. Date signed JULY 20,	(Month, Day, Year) 2005
		PATO TO A A CONTRACTOR	of death yllon zoes (Lype.	Printy	T COMPTEN	DATEST	DE MADE	AND 21 201
State Registra	_	31. Date filed (Month, Day, Year) 32/Rec	strar's Signature	TII PENI	N STREET	, DALLIMO	RE,MARYL	AND STROT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** AM HENRY EDWARD CLARK 8:10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RMCHIE NIA BALTIMORE | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | O7 - 24 - 1935 5. Social Security Number Birthplace (State or Foreign Country)

MS 7. Age (In yrs. last birthday) **Funeral** 1 MM 2 □ F 69 Yrs. 428.60.9844 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No MD NA Funeral Director BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with STREET 4902 STAFFORD USA 21229 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If itam 27 Is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 6TH GRADE MA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JESSIE CLARK ANNIE LOVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 MARBOURNE AVE. # 2C DAUGHTER YVONNE CLARK BALTO. MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ ARBUTUS 07.26.05 BALTO. MO * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signal re of Funeral Service License 5151 BALTO. NATI PIKE, BALTO. MO 21229 ang 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carceroma 16 months panchen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Division 1 Natural 2 Accident Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Fo the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License numbe cute 0009582 07/21/05 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ISOW. LANVALEST. BUTIMORE

MD 21217-4170

m, n, 15

Frank Chapman 05-4933 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	Maryland /	•			ealth a Death			iene •g. №.೧ (100	01
43.3	£ " \$	3*	Decedent's Name (First, Middle, La	st)				0, 2	Journ		2. Date of Dea	th Ct	105	6-Time of Death
	Physici /Medic		Frank Chapman	Jr.							July 2	1, ^{Day} 200	5 Year	3:07 P M
	Examin		4a. Facility Name (If not institution, giv	street and number	r)		4b. City	, Town, or	Location of	of Death			nty of Death	
4	Katha and Andrews		St. Agnes Hospit					imor		0.11			n/a	
	Funeral Director		5. Social Security Number 6. S 245-42-5430	ex 7. A EM 2□F	Age (In yrs. last b 73	Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day an . 24,	Year)	Cour	place (State or Foreign htry) h Carolina
188	-		Usual Residence of Decedent		7.5					9	an. 275	1732	NOTE	ii Calolilia
	nyland how	_	10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	Ba-f	Director	MD n/a		Baltin	nore								XXYes 2 □ No
	with th		10e. Street and Number				10f. Zi	p Code			1	0g. Citizen o	of What Cour	ntry?
	eath or 23	Funeral	504 South Smallw	od St.	nt Ever in U.S.	13 1	Was Dece	2122		gin? (Sne	city Yes or No-	US 14 R	A ace - Americ	ean Indian
(0	r tten	표	1 Never Married 2 Married	Armed Forces	s?						cify Yes or No- Rican, etc.)	В	lack, White,	etc.
03	72 hours after death with the Maryland naturalt, or iteme 23a or 28a-f ehow dical Esandrast mat Le notifiad al	t by	3K2KWidowed 4 □ Divorced	If Yes, Give Year or Dates	3:		1 ∐ Yes	24_1 No	Specify:	WIII	ce	Spec	cify: wh:	ıte
2-0		Completed	15. Decedent's E (Specify only highest gra		16	(Give	kind of w	al Occupa ork done d	during mos	t of workii	ng	16b. Kind of	Business/In	dustry
121	within ene. then	шb	Elementary/Secondary (0-12)	College (1-4o	r 5+)			se retired, ceman)			Sh	ipping	7
d 2	e filed within al Hygiene. I other than ' vent, ire me		17. Father's Name (First, Middle, Last,			30116	51101	Cilian	18. Mothe	er's Name	(First, Middle,			5
lan	lid be Sental rked o	To Be	Frank Chapman Sr						1177	know	n			
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 te marked other traumatic ev		19a. Informant's Name/Relationship (19	9b. Mailir	ng Addres	s (Street a			l Route Number	, City or Tow	m, State, Zip	Code)
	9 モ ト き		Kathie G. Grace -	Step Dau					n Ave					
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ C ematio. 3 ☐	Removal from Stat		tery, crer	natory or	other place				20c. Location	•	
Iţi.	Departmentimportant:		4 Donation 5 Other pecil	\rightarrow	Loudor						6, 05 B			J
Bal	permit. Departr imports any infi		21. Signature of Funday Service Lide	ISBB.							don Par			
	R J		27 Part. Enter the disease, or coo	plications that caus	ed the death. D						altimor		yland	Approximate
	Physician		shock, or heart failure. List only	one cause on each	line.				_					Interval Between Onset and Death
100	/Medical		disease or condition resulting in death)		ensive as a consequence		rosc	enos	- CON	910V	محدرام	dise	e	
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	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		is a consequenc	e of).								
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687	the the	edic		_ d										
Вох	ondir use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Petal dea	uh al]Ectopic p					23d. [Date of delive	ery
	ne death the atte	sicia	in the past 12 months? 1 Yes 2 No		at time of death		Other (s					N	Month	Day Year
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	Se G	ρ	Part II. Other significant conditions of	onthouting to death	Dut not resulting	g in the u	nderlying	cause give	en in Part I					ne cause of death?
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tal	ician: Th certificate ector, pag	ပိ	25. Was case referred to medical						OF Blood	of Dooth	1 Yes :	2 No	1 X Yes	2 No
		To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 TERV	Outpatier	nt 3□ D	OA Othe	25		ne 5 🗆 Reside		other (Specif	v)
o c	D D D		27. Manner of Death 1 Natural 5 Pending	28a. Date of In	jury 28b	. Time of		28c. Injury Work			28d. Describe h			,,
Sio	Attending r death. actor: After by the fune	catic	2 ☐ Accident investigatio				М		Yes 2 🗆	No				
Division	l or Attendir after death. Director: Af in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, str	eet, factor	y, office		2	28f. Location (S. City or Town	treet and Nur n. State)	nber or Rura	al Route Number,
	Hospitel of the hours all Eunaral D		29a Certifier 1 Certifying Ph	ysiolan: To the bar	et of marketonical	los toni	h tenning.		of Makera	of charge of	out and a second	200000000000000000000000000000000000000		me d
	To the Hospitel or Attenwithin 24 hours after deatl To the Funaral Director: completely filled in by the	edical		niner: On the basis and manner	of examination	and/or in	vestigation	n, in my op	oinion, dea	th occurre	ed at the time, d	ate and place	e, and due to	the cause(s)
	To the within To the compl	₩	29b. Signature and title of certifier				29	c. License	number		2	9d. Date sign	ned (Month,	Day, Year)
	1		1 dass	Jeen	PMP			0.0	.M.E.		J	uly 22	2.00	5
	h			completed cau	death (Item 23a									
			Josha Z Gre	enberg	M.D.		1 Per	nn St	reet,	Bal	timore,	Maryl	and :	21201
	Sta Registr	100	31. Date filed (Month, Day, Year)	- C	strar's Signature		medi	9						

DHMH 17 Rev 1/2001

		1	For Stata Registrar	State of Marylan		artment rtificate				giene	0 E	21216
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath C. U	U) _	3. Time of Death
	Physicia		Reta Jane			Co1	lison		July	Day 21	2005	3:18 P M
)	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, To	own, or Loca	ation of Deatl	n	4c. County	of Death	
			615 Hopkins Street				oklyn			Anne	Arun	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 73		If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Bird (Month, Da June 4	h y. Year)	9. Birthp	lace (State or Foreign htry)
l,	Director		212-30-1098	^{M 2} X ^F 73	Yrs.				June 4	, 1932	MD	
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary Feb	ţ	MD Anne Arur	nde1	Е	rookly	vn Par	k				1 ☐ Yes 2 ☐ No
	h the	lrec	10e. Street and Number		77.0	10f. Zip 0				10g. Citizen of	What Cour	ntry?
	th wit	a D	615 Hopkins Street			21	1225			U.S.A	•	
	eme er m	Funeral Director	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decede	nt of Hispar	nic Origin? (S exican, Puer	pecify Yes or No to Rican, etc.)	- 14. Rac	ce - Americ	
20	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 🗆 Yes 2		oecify:		Specil		ite
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7	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cat	erer				Foo	d Ser	vice
and	e filled at Hygis I other vent, I	Bec	17. Father's Name (First, Middle, Last)						me (First, Middle,	Maiden Sumai	me)	
Ja	Mentel Mentel arked c	2	Howard Lowery					Mary (Grady			
Mar	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Heelth and Mentel Hygiene the file of the state of \$88=1 show item 27 is marked other then "natural", or items 23s or \$88=1 show other traumatic event. The Madical Examinar must be notified at	1	19a. Informant's Name/Relationship (Type		_				ural Route Numbe			Code)
رن د	1 and 2 1 deelth 1 om 27 i	1	Mr. Edgar Collison 20a. Method of Disposition					eet, i	Brooklyn Date	20c. Location		Ctate
E	permit. Pages 1 and Department of Heel Important: if Item 2 any Injury or other once.	. 1	1 🔀 Bultial 2 🗀 Cremation 3 🗀 Re	movan mom State	Place of Dispo			-1- 7/24			•	
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ğ	Dep Imp		+ ax X I le	66110M -					.W., Gle			
		1	23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused the deat	h. Do not ent	er the mode	of dying, su	ich as cardia	or respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as)a conseq	uence of):		1 1)	7			2	1 1
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	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uende of):			0				
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X Q Q	leath certifice ettending ph i for use as th	20	230. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pre	onancy				ate of delive	•
n	e death he etter hed for u	Physician/Med	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐ Pregnant at time of d		Other (spe				M	onth	Day Year
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VITA		ပိ	25. Was case referred to medical				26	Place of Do	1 ☐ Yes ath (Check only o		1 🗆 Yes	2 No
	Physician: this certific ral director,	To B	examiner?	ospital:	ER/Outpatier	nt 3 DOA	Othor		dome 5 🕅 Resi		her (Specif	(v)
ם ר	ding Phye h. After this funeral di		27. Manner of Death 1 ☐ Haturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28	c. Injury at Work?		28d. Describe	how injury occu	rred	,,
<u> </u>	Attending r death.	catle	2 Accident investigation			М		2 🗆 No				
Division	P # # C	Certlflcation:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specil	ome, farm, st fy)	reet, factory,	office		28f. Location (. City or To	Street and Num wn, State)	ber or Rura	al Route Number,
_	purs ours fille		29a. Certifier 1 Dertifying Physi	ician: To the best of my kno	owledge, deat	h occurred a	t the time. d	late and place	e, and due to the	cause(s) and m	anner as s	tated.
	the Hos nin 24 hi the Fun npletely	edical	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, i	in my opinio	n, death occi	urred at the time,	date and place,	, and due to	the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	VD C		29c.	License nui	mber		29d. Date signe	ed (Month,	Day, Year)
)	1		Ellet	proved !	91)	1)2	009	4		01/2	2/04	7
ĺ	0		30. Name and address of person who con	npleted cause of death (Iter	m 23a) (Type,	Print)	2	Q. 1	· Anc.	o (Qo.	Birth	o and reall
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature _	Villa	rsen	lour	- W/W	1	ויוטע	/ FH X106
	Registi		31. Date filed (Month, Day, Year) JUL 2 6 2005	Blocker S.	Cose	Kes .						

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. the à Records, pe page 2 s Ser certificate Division of Vital this

Physician /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) sedale ranklin Lave If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days Hours Months Min. 1 □ M 2 🕅 F 177-22-9335 76 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location itam 27 is marked othar than "natural", or itams 23a or 28a-1 show othar traumatic svant, the Medical Exumination relative motified at MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 7159 Oliva Road 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker 17. Father's Name (First, Middle, Last) Be and Mental Charles Welliver 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 Is any injury or other tra Gail Janes / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 21. Signature of Funeral Savice Licensee any ir 1211 Chesaco Avenue Immediate Cause (Final disease or condition resulting in death) Pulmonar **Physician** Lmholisi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Varian Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Hospital or Attending Physician: Be 25. Was case referred to medical examiner' Other: P 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After 1 HNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a cal 29a, Certifier (Check only one) tha 29b. Signature and title of certifier 0 0061402 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square 31. Date filed (Month, Day, Year) State 2005 JUL 2 6 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Year Ordell Curran 200 11 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) 8/16/1928 Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Winters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8205 Sagramore Road Rosedale, MD 21237 20c. Location - City or Town, State 7/29/05 Rosedale, Maryland 22. Name and Address of Facility Cvach/Rosedale Funeral Home Rosedale, MD21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 0 Drive Balto MD

			For State Registrar	State of Maryland / De	partment of Health and I <i>ertificate of Death</i>	Mental Hygiene Reg. No		24348
T		7	Decedent's Name (First, Middle,			2. Date of Death		3. Time of Death
	Physici /Medio		hobert J	ames Croys	e	JULY 2	3 2005	01:45AM
}	Examir		4a. Facility Name (If not institution,		4b. City, Town, or Location of Death	40	. County of Death	
W.		**		HEALTH CARE 6. Sex 7. Age (In yrs. last birthda	BACTIMORE av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0.8:	Jana (State - Fee:
B	FuneralDirector		219.40.8105	10 4 20 F 6 Yrs.	Months Days Hours Min	(Month, Day, Year) Coui	place (State or Foreign ptry)
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	the N	Director	10e, Street and Number	1241	timore 10f. Zip Code	100 0	tizen of What Cour	
	3a or			Kland Road	21227	7	4.5	i .
	deeth	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Americ	an Indian,
36	or It	by Fu	1 Never Married 2 Marrie	ed 1 Tyes 2 THO	1 ☐ Yes 2 ☐ No Specify:	o riicari, etc.)	Black, White,	
215-0036	within 72 hours after deeth with the Maryland jiene. r then "natural", or Iteme 23a or 28a-1 show Ite Midical Examinat must be molified at	ed b	3 Widowed 4 Tovorced	Year or Dates:	cedent's Usual Occupation	1ch	(ind of Business/In	
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21	filed with Hygiene ther the	Com	8th	College (1-401 3+)	Plumber	- P	14 mk	Ding
pu	be dala	Be	17. Father's Name (First, Middle, L	•	18. Mother's Nar	ne (First, Middle, Maidei	•	J
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Ma	2 a .		, and 3	nCrouse/Brother 3	alling Address (Street and Number or Ru			· ·
re,	es 1 and 2 of Health of fitem 27 r other tra		20a. Method of Disposition	20b. Place of Dis	sposition (Name of crematory or other place)	Date 20c. L	ocation - City or To	own, State
mo			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 Hemoval from State		28-05 B	- Ito m	D
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service L	icensee	22. Name and Address of Facility	19-121-5:	Stric idr.	15+
	8.0 E 8 8	0	- Change 10	l'ele	Integrity tunes	ral Services	134 1to	
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à.	Examiner			ALCHELIC LIV	EL DISEASE			YEARS
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
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Box	leath certifi attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	o□r		23d. Date of delive	ery
	e deat he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
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	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		. County of Death
			THE JOHNS HOPKINS HOSPITAL		CTY	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 218-01-7408 1 M 2□ F 87 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Birthplace (State or Foreign Country)
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מ מ	Departm Importa any inju			8900 REISTERSTOWN		
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n feed	e atte	sicia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
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Vital	s certific lirector,	o Be	25. Was case referred to medical examiner? 1 \[Yes \] 2 \[No \] Hospital: 1 \[\text{Topatient} \] 2 \[\text{ER/Outpati} \]	Othor	ath (Check only one)	C. T. Oahor / Coop f :)
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<u>ا</u>	ral D					
DIVISION OF VITA	within 24 hours after death. To tha Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dead (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause(s irred at the time, date an) and manner as stated. d place, and due to the cause(s)
Total	within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
•	16		E.S. Sutine , MEDICAL DOC	TOR RES-000	2	ULY 21, 2005
1) "	-	30. Name and address of person who completed cause of death (Item 23a) (Typ		Dall wins	MD 21587
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 190190 01-	JUNIU 1	0/20/
	Regist		JUL 2 6 2005 Beauco B.	Conti		

		For State Registrar		laryland / Depa	rtificate of D	Death	Re	2005	24350
Physician	_	Decedent's Name (First, Mid RITA	ldle, Last)	DA	VIS		2. Date of Deat Month	Day Year	. //.c. 01/
/Medical		Facility Name (If not instituti	ion, give street and number		4b. City, Town, or	Location of Death	July	22 2005 4c. County of Dea	5 1.00
Examiner	-	THE Johns Hope Social Security Number	INS HOSPITAL	, ge (In yrs. last birthday)	BALTIMO If Under 1 Year		8. Date of Birth	NA	irthplace (State or Foreign
Funeral Director	2	03-46-234	Ø 1□M 2\SF	50 Yrs.	Months Days	Hours Min.	(Month, Day,		nnsylvania
tel	10	a. State 10b. Coun	ity	10c. City, Town or Lo					10d. Inside City Limits
28a-f	10	e. Street and Number		BACTIN	10f. Zip Code		11	Og. Citizen of What C	1 1 Nos 2 No
ms 23a or 28a-f show rmust be nutlified at neral Director	1		over st		2121	8		USA	outing.
or its	11	. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	? INo	Was Decedent of His If Yes, specify Cubar I ☐ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
			ent's Education hest grade completed)	(Give	dent's Usual Decupa kind of work done d DQ NOT use retired)	uring most of worki	ng	16b. Kind of Busines	s/Industry
yiene. In Man		Elementary/Secondary (0-12)) College (1-4or	5+)	Mariali	reper		Domest	il .
Health and Mental Hygiene. Item 27 Is markad othar thsn "natu othar traumatic svent, tre Medical To Be Completed	17 1	Father's Name (First, Middle Arthur L	e, Last)		6	18 Mother's Name HOSA L	ee Ho	Maiden Sumame)	
salth and n 27 is mu iar traum	1	a. Informant's Name/Relation	nship (Type, Print)	19b. Mailin	ng Address (Street a	nd Number or Rura	Route Number,	City or Town, State,	Zip Code)
Dep riment of Health a Important: If Item 27 Is any injury or othar trau once.	20	a. Method of disposition	n 3 Removal from State	20b. Place of Dispo		2/1/0		20c. Location - City o	r Town, State
tment tant: I		`4 □ Donation 5 □ Other	(Specify)	14 Z107	1 Jemelan	d : Jx	8/05	BALGO L	(P)
Departing any injured once.	21	I. Signature of Funeral Service	ce Licensee	22	2. Name and Address	s If Facility (\(\sigma\)	MATON C		Stungal Savid ACTO, MD 2121
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Richard Η. Elliott 2316 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner J.H.H. Baltimore NA If Under 1 Year If Under 24 Hrs.

Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 220-05-4662 Yrs. 87 12-10-1917 Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Medical Exacting must be notified at Md. NA Baltimore Director X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2713 E. Monument Street "natural", or items 23a 21205 USA death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or ite may injury or other traumatic evant, the Medical Errar if an once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Elliott Addie Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Loretta Thornton 6922 Rockfields Rd., Baltimore, Md. Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State Druidridge Cem. 7-23-05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC disease or condition resulting in death) YRS /Medical Due to (or as a consequence of): Examiner 1PHM SEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury de a consequence o Examine nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown á been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ PULMONARY PULMONALE WITH 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy ADRIC STENSIS ADRIC VALL ROAMENLA certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death Check onlone Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient ^o 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 4 hours after death. Funaral Director: A death. 1 ☐ Yes 2 ☐ No investigation ☐ Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide .n 24 hou. •ha Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 EAST 332" ST. BAYTMONE MD 31. Date filed (Month, Day, Year) 32. Bigistrar's Signature JUL 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 -1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Tayon Freeman /Medical 4a. Bacility Nama (If not institution, give, street and number) 779UMQ 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BaHIMOre n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year | 7 / 3 / 1 9 8 9 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 16 Director 217-25-1403 Yrs. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at Maryland Completed by Funeral Director 1 ☐ Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 3618 Benson Avenue filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student Education .. Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: if item 27 is marked other t jury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Freeman, Sr. Brenda Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Benson Avenue, Baltimore, Maryland 21227 Brenda Forney - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. Cedar Hill Cemetery July 22,2005 Brooklyn Park, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only directause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 7041S /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 2days P.O. Box 68760 Certification; To Be Completed by Physician/Medical MEDICAL 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery APPROVED BY Month Day Year 4☐Pregnant at time of death been signed by the s should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 20 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury
(Month, Day Year)

28b. Time of
Injury
(Month, Day Year)

4 16 2055 940 AM 27. Manner of Death 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ N within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Chack only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11453 HAWAN 1/2 Greene St. Baltimore, Mc 2120 State Registrar

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	/Medic Examin	41	4a. Facility Name (If not institution, give Union Memorial	street and number)		b. City, Town, or Baltimo	Location of D	eath	4c. County	of Death	1
0	, Funeral Director		211.84.6427	$\frac{1}{2}$ M $\frac{1}{2}$ F $\frac{7}{3}$ Age (In yrs. last		f Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Birl Min. (Month, Da	1968	9. Bighpl	ace (State or Foreign
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	with the M a or 28a-f	Direct	10e. Street and Number	AIC		10f. Zip Code) I) IS		10g. Citizen of	What Coun	try?
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215-0036	noture of the no	b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates:	6a. Deceden	Yes 2 W No	Specify:		Specif	- 54	ACK dustry
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Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tha Magnee.	To Be	17. Father's Name (First, Middle, Last) CHARLES F	TWLKES			18. Mother's	Name (First, Middle, ERTHA	Maiden Sumar	0N	
	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (1 BERTHA ? CHARUES	FOULKES (AARONS	22	Address (Street a	CIL F	HE. GA	THURE	State, Zip	Code)
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Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licen	Siv	22. N 491	lame and Addres	s of Facility K ROA	AUGHN C D BAITIN	ORE, M	VE FOI	NEXAL HONE ND 21212
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	withis To the	Σ	29b. Signature and title of certifier	0 0		29c. License	number C.M.E.		29d. Date signe		
			30. Name and address of person ho	completed cause of death (Item 20	Sa) (Type, Pri	int)			July 2		
1111			Tara - Gra	MINCH THIS		11 Penn	Street	, Baltimo	re, Mar	yland	21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	CAL	2					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 23, 2005 DARRYL GRAY JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6614 VINCENT LANE, APT. #101 BALTIMORE CITY N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Hours Yrs. Director 215-44-9663 05/05/1945 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23s or 28e-f show other treumatic event, the Woolcal Examinating the notified at N/A MD Director BALTIMORE CITY XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 VINCENT LANE, APT. 101 21215 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2X Married 1 Yes XXNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) 12TH College (1-4or 5+) TRUCK DRIVER AUTOZONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Pages 1 and 2 should be CHARLES GRAY, JR. ALMERETTA TYSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) item 27 I CHARLENA A. GRAY / WIFE 6614 VINCENT LN, APT. 101, BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Importent: If eny injury or once. 7/28/05 PIKESVILLE, MD DRUID RIDGE CEM. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE BALTIMORE her. Enter the disease, or complications that caused the deat ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear so not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician dise e r condition result in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner or Attending Physiclen: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Dthe significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check onl o e examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🗆 Nursing Home Certification: To 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Reliedent Ave. BALTIMONE UND 21215 State Registrar

			1 - State of Maryland / Departing State of Maryland / Departing Certification	ment of Health and N icate of Death		ene 2005	21,355
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		Mary Elizabeth Grannan 4a. Facility Name (If not institution, give street and number) 4b.	. City, Town, or Location of Death	JULY	22 200 4c. County of Dea	3 11:20
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	3a 1 fm ove Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, August 1	Year) Co	thplace (State or Foreign unitry) yland
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10b. Baltimore Catonsville	on			10d. Inside City Limits 1 ☐ Yes 2XXNo
	with the	Dire	10e. Street and Number	Of. Zip Code	10	g. Citizen of What Co	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any figury or other traumatic event, the Modical Eventil or roual by Indillied at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	21228 Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit	
21215-0036	within 72 ho one. than "natur e Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kinc life. DO l	s Usual Occupation f of work done during most of work NOT use retired)	iing	6b. Kind of Business	•
Maryland 2	d 2 should be filed within " h and Mental Hygiene. 7 Is marked other than " traumatic evant, the Med	To Be Co	12 – Administ 17. Father's Name (First, Middle, Last) William H. Nossel		e (First, Middle, Mi hanberge	,	.e
	and 2 shousaith and Masser 127 is mai			ddress (Street and Number or Run neside Rd., Balt			Zip Code)
Baltimore,	Pages 1 ment of He ant: If Itan ury or oth		20a. Method of Disposition 1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator BWC	n (Name of rry or other place) 7/29/		oc. Location - City or aurel, MD	Town, State
Balt	permit. Depart Import any inj			me and Address of Facility Ling Ashton Sch Edmondson Ave.			
8760, 💢	cate be executed /Medical Examiner into burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	- (1000)	or respiratory arres	ξξ,	Approximate Interval Between Onset and Death 2 mon this 2 mon this 2 mon this
O. Box 6	The law requires that the death certific Ite has been signed by the attending p tage 2 should be detached for use as	by Physician/Mec		opic pregnancy ner (specify)		23d. Date of de Month	ivery Day Year
rds, P.	w requires that been signed b should be delt		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	o the cause of death?
al Records,		Completed				eg/ death?	topsy findings available completion of cause of 2□ No
f Vital	N Si	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ₩0 Hospital: 1 ☑ mpatient 2 ☐ ER/Outpatient 3	Out	h <i>Check on one</i> ome 5 ☐ Residen	ce 6 □Other (Spe	cify)
Division of	ding Pt h, After th funeral	Certification:	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		
Οį	o after		4 ☐ Homicide building, etc. (Specify)		City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigated.	curred at the time, date and place, gation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To t com	2	29b. Signature and title of certifier Molammed mp	29c. License number		d. Date signed (Monti	
i	Sta Begist		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Nareesa Mohammed 900 S. Caton Ave 31. Date filed (Month, Day, Year) Registrar's Signature	Baltmore, M	D 21225)	

DHMH 17 Rev 1/2001

MARY

GRANNAN

		1 - State Registrar	ate of Maryland	•	rtment of H		_	giene Reg. No.		
Physic		1. Decedent's Name (First, Middle, Last) VIRGINIA ELIZA	RETH		RAY		2. Date of De Month JULY		7.5	2 Time of Deing 9:09 A M
/Medi Exami		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of Death	3011	4c. County of		9:09 A M
	B	1310 ASTER DRIVE			GLEN BU	JRNIE		ANNE	ARU	NDEL
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 5-22-1	930	9. Birthpl Coun	lace (State or Foreign try) MD
puq *		Usual Residence of Decedent 10a. State 10b. County	10c City 1	Town or Loc	ration				[4]	Od. Inside City Limits
/anyla	5	MD Anne Arunde		len Bı					'	1 ☐ Yes 217 No
28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	
h with		1310 Aster Drive			21061			USA		
"natural", or items 23a or 28a-1 show	Funeral	1 ☐ Never Married 2 ☐ Married 1	Vas Decedent Ever in U.S. med Forces? ☐ Yes 2 No	If	Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)		- Americ , White,	an Indian, etc.
hours a	d by	3 KJ Widowed 4 ∐ Divorced	Yes, Give ear or Dates:		Yes 21 No	Specify:		Specify:		√hite
	olete	15. Decedent's Educatio (Specify only highest grade cor	npleted)	(Give k	ent's Usual Occupa kind of work done d OO NOT use retired,	uring most of worki	ng	16b. Kind of Bus	iness/Inc	lustry
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be file of oth	Be	17. Father's Name (First, Middle, Last) Louis Frederick Pa	lmar			18. Mother's Name		<i>Maiden Sumame</i> th Mann)	
hould id Mei mark	2	19a. Informant's Name/Relationship (Type, F		19b Mailin	n Address (Street a	nd Number or Rura			itate Zin	Code
nd 2 solith ar		Mrs. Linda J. Collet				ve, Glen				0000)
of Hee		20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name of satory or other place		Date	20c. Location - C		wn, State
. Page tment tent: ff		1 ☐ Burial 2 🛣 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		sapeal	ke Cremat	ion 7/22/		Stevens		
Depermit Deper impor any in		21. Signature of Funeral Service Licensee	M01364	4 1	Name and Address Second A	s of Facility Sing ve Sw Gle	leton l n Burni	Funeral I Le MD 210	Home 161	P.A.
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused the death. use on each line.	Do not ente	er the mode of dying	g, such as cardiac c	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		clero-	tie /	tear	+ 1)15	CA.	5-L
Examiner		Sequentially list conditions b	Due to (or as a consequen	nce or).						
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):						
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ate be	edical	d								
certific		IF FEMALE: 23c. II	yes, outcome of pregnanc	y				23d. Date	of delive	
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uires that t signed by id be detad	by Ph	Part II. Other significant conditions contribu	ting to death but not resulti	ng in the un	derlying cause give	n in Part I.	23e. Did t	obacco use contri	oute Io th	e cause of death?
w require been sig should b							10	Yes 2 □ No	B 🗌 Prob	ably 4 Ounknown
2 8 2	Completed						24a. Was autop perfo	osy pr ermed? de	ere autorior to con ath?	osy findings available inpletion of cause of
clan: ertifice	Be	25. Was case referred to medical examiner?				26. Place of Death				20110
Physic this co	2	1 Nes 2 No Hospi	1 Inpatient 2 EF	NOutpatient		4 Nursing Ho		dence 6 Othe)
Attending Physician: The ridgeth. The continue of the continue of the physician of the phys	tlon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	Ba. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at ? ′es 2 ∐No	28d. Describe I	how injury occurre	d	
or Atter siter dea Director in by the	ertification:	3 Suicide 6 Could not be	Be. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (: City or To	Street and Numbe	r or Rura	Route Number,
To the Hospitel or within 24 hours effe To the Funerel Dir completely filled in	O	29a. Certifier 1 Certifying Physicia	n: To the best of my knowle	edge, death	occurred at the tim	e, date and place,	and due to the	cause(s) and man	ner as st	ated.
the Hin 24 the Fi	Medical	one)	On the basis of examination and manner stated.	n and/or inv						
Co. T. S. P.	-	29b. Signature and title of certifier	De	put	29c. License	number 00605		29d. Date signed	(Month, I	Day, Year)
n <		30. Name and address of person who comple	etec cause of death (Item 2	(3a) (Type, I			′		1	
<u>")</u> `		William P	JONE	SIN	10 6	95 A	mer	ica	2	1035
St Regist	ate trar	3f. Date filed (Month, Day, Year) 2 6 2005	32 Registrar's Signatur	So	whe					

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Marylar	•		lealth and N	Mental Hygier	2005	24357
Physici /Medic		1. Decedent's Name (First, Middle, Las JENNLE		REEN	1		2. Date of Death Month	2 2005	3. Time of Death 02:14 PM
Examir		4a. Facility Name (If not institution, give HARBOR HOSP				Location of Death	4	c. County of Death	
Funeral Director		5. Social Security Number 6. S 212-20-2777 Usual Residence of Decedent	ex		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 12 24	9. Birth Cou	place (State or Foreign Intry) MD
faryland show	ō	10a. State 10b. County		ity, Town or Loca					10d. Inside City Limits ★文Yes 2 □ No
h the h or 28a-f	irect	MD NA 10e. Street and Number	B6	a I C I MOI	10f. Zip Code		10g. (Citizen of What Cou	
ath wit	raiD	833 West Pratt				1201		U.S.A.	
Dealtimore, IMaryiding Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show may injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 ※ Armed If Yes, Give Year or Date		as Decedent of H Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	, etc.
vithin 72 ho	Completed	15. Decedent's Ec (Specify only highest year Elementary/Secondary (0-12)	College >+)	life. De		during most of work f)		Kind of Business/Ir & O Rail	
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DallIMOTe, permit. Pages 1 a Department of Her Importent: If item any injury or othe	1.75	20a. Method of Disposition	20b.	Place of Disposi				Location - City or T	
dillinor mit. Pages partment of portent: If it y injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				ery 7/2	7/05 Ba.	ltimore	Co, Md
Depa Impo any ii		21. Signature by driefal Service Eldal	Varil	Mai	Name and Address CCh F/H	West	Baltimo	ra. Mđ	21215
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The Colds, F.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3 □8	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
w requires that been signed be should be detailed.	by P	Part II. Other significant conditions of ACUTE Rend		sulting in the unc	derlying cause give	en in Part I.	23e. Did tobacco	use contribute to to	he cause of death?
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eath. or; Aft	atio	T Natural 5 Pending 2 Accident investigation		Injury		K? Yes 2□No			
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24 hor 24 hor Fune etely fi	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the tine estigation, in my of	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier			29c. License	e number	29d. D	ate signed (Month,	Day, Year)
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17		30. Name and address of person who HIRM GEBREWO	(P 5001 501	14 H70	rint) ANOUTR	Smeon	Baltin	10,2 M	21225
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			Tor State Registrar	State of Maryland /	Depa		ealth and i	Mental Hy	giene		
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	Director		219-10-7090 ¹□ Usual Residence of Decedent	^M 2√2 F 78	Yrs.	Months Days	Hours Min.	Jan.7	1927		niny) vland
	yland		10a. State 10b. County	10c. City, To							10d. Inside City Limits
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	2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show aumatic event, the Madical Examinational September Collified at	Funeral Director	10e. Street and Number 3657 Park Heigh	ts Avenue		10f. Zip Code 2121	5		10g. Citizen of USA	What Cou	ntry?
	deat	ner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No	- 14. Ra	ce · Ameri	
9	or Ite	Fu	1 Never Married 2 Married	1 Yes 2 XNo	1	☐ Yes 2 No	Specify:	o mican, etc.)		ack, White, ., Bla	
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yland	ould be f Mental I arked or atic eve	To Be	Willie Walters				Edna Ma		, Maiden Suma		
Mar	alth and 27 ie m		19a. Informant's Name/Relationship (Type Sharon Hill/ Da		96. Mailin 557	g Address <i>(Street a</i> Park He	ights A	ral Route Numb Ave Ba]	Ltimor	e, Ma	aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Arbut	of Dispos ery, crem Lus	sition (Name of natory or other place Memoria	7/26 1 Park	5/07 y	20c. Location rbutu		own, State aryland
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ó	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consequence	e of):						
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Вох	death certifical e attending phy of for use as th	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3□	Ectopic pregnancy				ate of delive	,
о. В	0 0 0	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐ Unknown		Other (specify)			N	fonth	Day Year
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Division of Vital	or Attending after death. Director: After din by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, stre			28f. Location (Street and Nun	ber or Run	al Route Number,
2	after Dire	Certification;	4 Homicide	building, etc. (Specify)		,,		City or To			
	To the Hospitei within 24 hours s To the Funerei! completely filled		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	ge, death	occurred at the tim	e, date and place	, and due to the	cause(s) and n	nanner as s	tated.
	he Ho n 24 he Fu	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examination a and manner stated.	and/or inv	estigation, in my op	oinion, death occu	rred at the time,	date and place	, and due t	o the cause(s)
	To the Hospitei or At within 24 hours after of To the Funerel Direct completely filled in by	Σ	29b. Signature and title of certifier			29c. License			29d. Date sign	ed (Month,	Day, Year)
l	{		Rachel Hartin	an M.D.		RES	- 000		July	20	2005
	χ		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, I	Print)					
	1		Rachel Hartman	m M.D. Si	nai	Hospital =	+ Balt	nove			
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 6 2005	32. Registrar's Signature	book	i					

DHMH 17 Rev 1/2001

HIII, Edna M

State of Maryland / Department of Health and Mental Hygien 15 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Frank Hugo Holquist July 21 2005 12:35 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2930 Frederick Avenue Baltimore n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F 523-18-1549 Director 83 Yrs Apr 12, 1922 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Mcdical Examiner must be mailied at 1XYes 2 □ No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2930 Frederick Avenue 21223 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No ρ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Tyer Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Holquist Alice Marie Hazlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie M. Bryant 2930 Frederick Avenue, Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or oth Date 20c. Location - City or Town, State 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery Donation 5 Other (Specify) 7/23/2005 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. ature of Funeral Service Licensee white 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA UKNOWN PRIMARY **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Month Day Year 4☐Pregnant at time of death 5 Cher (specify) detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No in by the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time date and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE EWCOLE AGNES 31. Date filed (Mon L 2 6 2005 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year NORMAN HEATHCOTE TUL 2105 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORIE BALTIMORE " KESWICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year) 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 15 L 1 C L Months 220-07-7639 Yrs. Director 86 DEC 23, 1918 of Columbia Usual Residence of Decedent filed within 72 hours efter death with the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 W. 36th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White "naturai", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental Norman Heathcote Minnie Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine Heathcote/wife 1454 W. 36th Street Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 7/26/05 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Interstitial Lung Disease Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): $\mathcal{O}(\mathcal{H}_{\mathcal{L}},\mathcal{I}_{\mathcal{M}_{\mathcal{M}}})$ Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Obstactive Pulmonary 1 Nes 2 No 3 Probably 4 Unknown Be Completed by sete has been signe page 2 should be 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 27. Menner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical To the Vithin 2 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July, 25, 2005 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Black, 6565 North Charles St. Suite 203 PPE, Towson, MD 21204 31. Date filed (Month, Day, Year) 32/Registrer's Signature

Registrar

JUL 2 6 2005

		1 - For Unpend Item 2	State of Maryla 23a,pt.II,27	nd/Departme per me e Chris	ent of Health and atd of Deathtas	Mental Hygie	ne	0:
Physici /Medio		1. Decedent's Name (First, Middle, Las				2. Date of Death	Day Year 2005	4:55 A M
Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Dea		4c. County of Dea	
		1525 North Rollin	9		Consville		Baltimore	County
Funeral Director		5. Social Security Number 6. Security Number 10. Security Number 1	M 2XF		ns Days Hours Mir		918 F	thplace (State or Foreign ountry) -0RIDA
vith the Maryland or 28a-f ehow	tor	10a. State 10b. County		3AUTIN	IORE			10d. Inside City Limits 1 PYes 2 □ No
	al Director	10e. Street and Number 1604 N. Bol	UD STREE		Zip Code 21213	10g.	Citizen of What Co	ountry?
1036 ours after death rai', or Iteme 23. Examiner must	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: 18	
d 21215-0036 filed within 72 hours after Hygiene. then "natural", or Ite Mudical Examina	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	life. DO NO	work done during most of w	orking	Kind of Business	,
be file be file and oth	To Be C	17. Father's Name (First, Middle, Last) WILLIAM SIN	GLETARY		18. Mother's Na SALU	ime (First, Middle, Maid IF BROW	len Sumame)	
Ma nd 2 s lith ar 27 is r trau		19a. Informant's Name/Relationship (T. REV. RICHARD TAI	BRON (NepHEN	1) 1353 1	oss (Street and Number or F NINSTON AVE	· BALTO, M	0.2123	9
mor Pages ent of ht: If it		20a. Method of Disposition 1	3	ING PARK I	EMETERY 7/3	29/05 B	Location - City or ACTIMOR	CE, MD
Baltii permit. F Departm importar any inju		21. Signature of Funeral Service of the	Lene -	22. Name 4905	YORK ROAD	HUGHN C. BALTO, M	GREENE D·2121	FUNERAL SO
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limited the cause (Final disease or condition resulting in death) Sequentially list conditions,	ne cause on each line.	Atheroscl	erotic Cardio	ac or respiratory arrest,		Approximate Interval Between Onset and Death
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Ords, P.O. BOX 08/00, requires that the death certificate be executed in signed by the attending physicien and nould be detached for use as the burial-trans	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	33c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of del Month	ivery Day Year
w requires that been signed to should be det	ed by P	Part II. Other significant conditions co Diabetes mellitus		sulting in the underlying	g cause given in Part I.		1.7	the cause of death?
The law ate hes b page 2 st	e Completed by	05. We				24a. Was an autopsy performed 1	prior to death?	topsy findings available completion of cause of 2 \square No
Or VIIIa Physician: this certific	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	fospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	Otto	ath Check only one	a Clau	
nding Physician: ath. r: After this certific e funeral director.	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residence		at scene
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h building, etc. (Speci	nome, farm, street, fact	ory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
ne Hospii n 24 hour ne Funar	Medical	29a. Certifier (Chack only one)	sician: To the best of my known. On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To ti vithii To ti comp	Σ	29b. Signature and title of certifier WAL (+a)	ilan md	2	9c. License number OCME	I	Date signed (Monti 1y 24, 20	
		30. Name and address of person who co	to ma	1	11 Penn Stree	et Baltimo	re, Mary	land 21201
Star Registra		31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature				

amend item#8, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

1- For Registrar Amend item#20b, perFH, G845, 7/29/05 TT Open The Registrar Registrar Reg. NZ. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GEORGE HAWKINS 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba H' MORD (' HY
If Under 1 Year Wunder 24 Hrs. 8) Date of Birth
(Month, Day, NA Hospital reneral Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 402.50.2059 1**2** M 2□ F Months Yrs. 03-02/08/1939KENTUCKY Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f show The Medical Exteriorar cost be notified at 1 XYes 2 No **Funeral Director** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 306 SIREET 2301 HOLLINS 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours alter 1 ☐ Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER SELF EMPLOYED 1214 GRADE NA other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ia marked of 99 Pages 1 and 2 should be ment of Health and Menta NELLIE GRAVES GEORGE HAWKINS, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 WOODHAVEN AVE., BALTO. MD KHODA HAWKINS (WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) GREENMOUNT 7/26/05 BALTO. MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALD. NATL PIKE BALTO. MD

23a. Part1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of). Examiner cena one month Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) death certilicate be executed burial-transit C. Due to (or as a consequence of): physiclen Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) luneral 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred Alter Hospitai or Attending Injury 1' Natural 5 Pending alter death. Director: Al 1 ☐ Yes 2 ☐ No М 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Thomicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22or our m.D 30. Name and addres f perso who completed cause of death (Item 23a) (Type, Print) Kathim Brown M.D. To Maryor Jeneral brown M.D Kath lyne 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar 1. South DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 5 24363 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** NELLIE HALL HAYNES JULY 25. 2005 0110 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death HOMEWOOD NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 🗆 M Yrs Director 245.09.5746 88 APRIL 11,1917 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Itams 23a or 28a-f show the Madical Examinations to mutilled at 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 WEST PRATT ST 21201 USA Funeral filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes XX No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Specify þ Specify: ₩Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 HOME MAKER OWN HOME other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental Figure 19 mit. Pages 1 and 2 should be partment of Health and Menta portant: If Item 27 is marked y injury or other traumatic or GEORGE HALL MARY BORDEAUX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 833 WEST PRATT ST BALTIMORE, MD 21201 MARY HILL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation XX Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. GREENLAWN MEM. CEM. WILMINGTON, NC unk 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. *K-CRECORY MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 . Enter the di leas. , or heart failure. 23a. Part shock or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or candition resulting in death) Physician Renal /Medical Due to (or as a consequence of): Examiner asestive Sequentially list conditions, if any, bading to introduce cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last the attending physician and C Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Hypertension this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diesetes Wellitor Type? autopsy 2□ No 1 🗌 Yes 2 ₩No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0059056 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Royal 31. Date filed (Month, Day, Year) MD Saloja 1600 MT

State

Registrar

Division of Vital Records, P.O. Box 68760.

32. pegistrar's Signature

DESTA

JUL 2 6 2005

pt Known as HUNT, URATH

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, 77

		amend item#26,pe	otate of Maryla		ertificate of		Mental Hy	ygien Reg. N		0 : 0 : .
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of D	eath	2003	3. Time of Death
/Medi	cal		Hunt				July	8		14-30 PM
Exami	ner	4a. Facility Name (If not institution, give st	1	MAN A T	4b. City, Town, Baltimo	or Location of De	ath	4	c. County of Dea	th
Funeral	7	5. Social Security Number 6. Sex		rs. last birthday) If Under 1 Year	If Under 24 Hr		irth	N / A	thplace (State or Foreign
Director		220 24 0703	^{M 2}	Yrs.	Months Days	Hours Mi		а <i>у, Үеаг</i> 25 .	7 0	Maryland
fand ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
a-f sh	ctor	Maryland N/A		Balti	more					1 X Yes 2 ☐ No
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, If a Medical Evantrat count te notified at	Director	10e. Street and Number 3130 Keswick Road			10f. Zip Code	21211		10g. C	itizen of What Co USA	ountry?
ns 23s	Funeral		. Was Decedent Ever in	115 12			Chacity Vac as hi			don todio
after or iter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	0.0.	Was Decedent of I		irto Rican, etc.)	0-	14. Race - Ame Black, Whit	e, etc.
ural;	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🏋 ∏ No				SpecitWhi1	ce
in 72 n "nat	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Dece (Given	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of w	orking	16b. I	Kind of Business	Industry
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be file	Be	17. Father's Name (First, Middle, Last)	111			18. Mother's Na	ame (First, Middle		n Sumame)	
should id Mer marke matic	2	19a. Informant's Name/Relationship (Type		cnown	ing Address (Ctross	hand Mumbaras 5			Unkı	
alth ar 27 is rr trau			Son	45	ing Address <i>(Street</i> 7 Main St	reet Re	istersto	wn,	MD 21136	(ip Code) D
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, if a Medical Eva any injury or other traumatic event, if a Medical Eva ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Real	20b	Place of Disp	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
t. Pag ntment rtant:		` 4 ☐ Donation 5 ☐ Other (Specify)	noval noin State	t. Zion	Cemetery	7 7/13	3/2005	Upp	erco, Ma	aryland
permi Depa Impo any ir		21. Signature Funeral Service Licensee	Men 1)	B	2. Name and Addre urgee—Her 631 Falls	ess of Facility 185-Seitz	z Funera	1 Ho	me, Inc.	21211
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the de	ath. Do not en	631 Falls ter the mode of dying	s Koad, I ng, such as cardia	Saltimore ac or respiratory a	e,M ırrest,	aryland	Approximate
Physician		Immediate Cause (Final disease or condition	Candia		who Han					Onset and Deathy
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		, -	,		-	
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):	othe Co	ardiova	iscular	4	seaso	30 years
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eath certificate be ex attending physicien for use as the burial	Physician/Medical	d.								
h certif anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome of preg						23d. Date of deli	/arv
e death he atte	sicia	in the past 12 months? 1 ☐ Yes 2 X No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Dectopic pregnancy Other (specify)	<i>'</i>			Month	Day Year
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uires l signe	d by	Damentic.	Anemia	saming in the t	riderlying cause giv	en in Parti.	10	Yes 2		the cause of death?
s been si	ompieted)					24a. Was			opsy findings available
The law	omo						autor perfe	osy irmed?	prior to c death?	ompletion of cause of
ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes ath (Check only o	2 XX IIo ne)	1	2 No
Physic this c	.T	1 Yes 2 No	pital: 1 ☐ Inpatient 2 [28a. Date of Injury	ER/Outpatier		-A formand	_		6 □Other (Spec	ify)
nding ath. r: After e fune	Certification;	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe	now injui	ry occurred	
er deg rector	tifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (S	Street an	nd Number or Rui	ral Route Number,
oltal o urs aft eral Di										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medicaf Examine	ian: To the best of my kr On the basis of examinand manner stated.	owledge, deat ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	11		29c. License	e number		29d. Dai	te signed (Month	Day, Year)
		1 Jung	lley	190	Do	0409	41	J	1/4 8,	2005
12		30. Name and address of person who comp	pleted cause of death (Ite	m 23a) (Type,	Print) ·	· 17-		C.	214	
Sta	te	31. Date filed (Month, Day, Year)	32. Signistrar's Sign	ature	2176	1 (105)	ITAZ U	10	X4712	WY
Registr		JUL 2 6 200	5 600000	K 1	made					

within 24 hours at To the Funeral D Hospital campletely the

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 \ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, OCME methell and Mine July 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

State Registrar 31. Date filed (M. nth, Day, Year)



			1 - For State Registrar	e of Maryland / Depa Cea	artment of F		ıtal Hygier	e PAAS	21.200
ı	Physici /Media		1. Decedent's Name (First, Middle, Last) EDWARD HAY	ES		,		2005 8 2005	-3. Time of Dedur
	Examir Funeral	er	4a. Fecility Name (If not institution, give street and MARYLAND CENE) 5. Social Security Number 6. Sex 1 M M 2 D	2AL HOSPITAL 7. Age (In yrs. last birthday)	BALT If Under 1 Year	r Location of Death IMDRE If Under 24 Hrs. 8. [Date of Birth	sc. County of Death N/A 9. Birth	place (State or Foreign
	Director		214-80-8/63 1⊠ M 2□ Usual Residence of Decedent 10a. State 10b. County	F 48 Yrs.	Months Days	Hours Min. (Month, Day, Yea -20-1958	B Misso	ntry)
	the Maryl r 28a-f sho	rector	MD N/A 10e. Street and Number	Balitmore	10f. Zip Code		10a. 0	Ditizen of What Cou	1X∑Yes 2 ☐ No
	death with	by Funeral Director	1107 W. Ostend Street 11. Marital Status 12. Was	Decedent Ever in U.S. 13. \d Forces?	21230 Was Decedent of H	ispanic Origin? (Specify	U.	S.A.	can Indian,
0036	hours after ural', or Ite	d by Fu	1 ☑ Never Married 2 ☐ Married 1 ☑ Y If Yes 3 ☐ Widowed 4 ☐ Divorced Year	(es 2 2 No 30-75 s, Give 0 6-30-75 or Dates: 07-28-75	I□Yes 2⊠No	an, Mexican, Puerto Rica Specify:		Black, White, Specify: Whi	ite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'lle Medical Examinan must be notified at ODGe.	Completed	15. Decedent's Education (Specify only highest grade completed processing (Specify only highest grade completed processing (Specify only 12) Elementary/Secondary (0-12) College	ted) (Give	DO NOT use retired	during most of working		Kind of Business/In	•
yland ;	ould be filed Mental Hyg arkad othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Golden Hayes			18. Mother's Name (Fir Dorothy V.			
	1 and 2 sho Health and Sm 27 is ma		19a. Informant's Name/Relationship (Type, Print) Sandra O Dell/Companio 20a. Method of Disposition	n 1107	W. Osten	and Number or Rural Ro	ltimore	MD 21230	
Baltimore,	iit. Pages artment of h ortant: If ite injury or of		1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee	Bayveiw	crematory or other place Cremator	y 07-25-2	2005 Ba	Location - City or To	
Ba	Depri impo		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do not ente		ss of Facility Ineral Home Onds Ferry I g, such as cardiac or res		downe downe MD	21227 Approximate
8760,	death certificate be executed Example a strending physician and and for use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Immediate Cause (Final disease) a. //(Immediate cause (Final disease))	OTE MYCCAR(DIAC IN	HFARCTTON A			Interval Between Onset and Death I - Z N DUK (
O. Box 6	the death certific y the attending p	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Records, P	The law requires that the de ite has been signed by the a bage 2 should be detached f	leted by Pr	Part II. Other significant conditions contributing	to death but not resulting in the un	derlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	
	(O) L	Comp					24a. Was an autopsy performed? I Ves 2 N	prior to cor death?	psy findings available impletion of cause of
on of Vital	ding Phys h. After this funeral di	tion; To Be	27. Manner of Death 1. ☑Natural 5 ☐ Pending (A	Inpatient 2 FVOutpatient ate of Injury Month, Day Year) 28b. Time of Injury	28c. Injury Work	4 Nursing Home			<i>'</i>)
Division	tel or Attending s after death. al Director: After ad in by the fune	Certification;	3 Suicide 6 Could not be	lace of Injury - At home, farm, stre uilding, etc. (Specify)		28f. L	ocation (Street a City or Town, Stat	and Number or Rura te)	l Route Number,
	To the Hospitel or within 24 hours after to the Funeral Dir completely filled in the completely filled in the formulately	edicai	one) and n	the best of my knowledge, death ne basis of examination and/or inv nanner stated.	estigation, in my or	pinion, death occurred at	lue to the cause(s the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
Λ	Towiti Con	×	29b. Signature and title of centifier 30. Na 22d dress pers my com leted of	Pause of death (flow 202) (Time	29c. License		29d. D.	ate signed (Month, 1)	Day, Year)
3	Sta	te	2 Na Main Ligor 31. Date filed (Month, Day, Year) 33	M.D. 827	Linden A	venue Balto	., MD 21	201	
	Registr		JUL 2 6 2005	Alser S. B.	parte				

			1 - For Stete Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of He tificate of D	ealth an Death	d Mental Hyg	iem 0 0	5 24367
	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	3. Time of Death
	/Medi		Charlotte	Harrison	1			07	21 20	005 12:10 A.M
	Examir	ner	4a. Facility Name (If not institution, give sti		!	4b. City, Town, or		Death	4c. County of	
	Funeral		Forest Haven Nursi 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Catonsvi	If Under 24	Hrs. 8. Date of Birth	Balt	
	Funeral Director			4 2⊠F 80	V	Months Days	Hours	Min. (Month, Day, Jan. 29,	Year)	9. Birthplace (State or Foreign Country) New Jersey
	p >		Usual Residence of Decedent 10a, State 10b, County	100-00	Town and			Built 27,	1,25	
	shov	2			y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	28a-f	ect	Maryland Baltimor 10e, Street and Number	e C	atonsv	111e		1.	0g. Citizen of W	
	3e or	Funeral Director	2103 Oak Lodge Roa	d		2122	g	,	U.S.A	700
	death	nera		. Was Decedent Ever in U.	S. 13. V			? (Specify Yes or No- luerto Rican, etc.)	14. Race	- American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show with injury or other treumatic event, ir a Madical Exertifier must be patified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cuban	Specify:	uerto Hican, etc.)	Specify:	White, etc.
5-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Deced	ent's Usual Occupat	ion	working	16b. Kind of Bus	
121	within and the second s	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired)			Hunting	0
	iled v Hygie ther t		12 17. Father's Name (First, Middle, Last)		Exec	utive Sec		Name (First, Middle, M		rian Church
and	d be f antai h (ed of	o Be	Charles H. Stephan	c				cence Lucke		9)
Maryland	12 should be filed within hand Mental Hygiene. 7 Is marked other than "freumatic event, Ire Mad	To	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street ar		r Rural Route Number,		State, Zip Code)
	and 2 alth a 27 is	1	John A. Harrison, J	r.(Husband)						yland 21228
Ore	of He of He fitem rothe		20a. Method of Disposition		ace of Dispos	sition (Name of natory or other place)				City or Town, State
ij	Pag ment ant: h		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	ioval irom State		h Cremato		-29-2005 L	aurel,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tree		21. Signature of Funeral Service Licensee	TESP	Wi	Name and Address tzke Fune	ral Ĥo	ome of Cato	nsville	. Inc.
	×		23a. Part1. Enter the disease, o complica shock, or heart failure. List only one	tions that caused the death	. Do not ente	or the mode of dying,	such as car	diac or respiratory arre	st,	Approximate
	Physician	0 11	Immediate Cause (Final disease or condition	ATHEROS	CHER	DIC (ERE	BRO VAS	CULAR	Onset and Death
	/Medical Examiner		resulting in death)	Due to or as a consequ	ience of):					136,196
	LAUMMO	<u></u>	Sequentially list conditions, b.	Due to (or as a consequ	are a					
	ted nsit	nlne	if any, leading to infinishate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequ	istice of).					
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):					
68760,	te be ysicia ie bur	edical	d.							
			IS SCHALC.							
Вох	The law requires that the death certiff tle has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy				of delivery
0.	to the deal by the a tached for	yslcl	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	ath 5	Other (specify)			Mont	h Day Year
△	res that the igned by be detact		Part II. Other significent conditions contri	outing to death but not resu	Iting in the un	deriving cause given	in Part I	23e. Did tob	acco use contrib	oute to the cause of death?
ds,	uires sign ld be	d by		•	3	,g g				Probably 4 Donknown
Vital Records,	w require been si should?	Completed						24a. Was an	24h W	ere autopsy findings available
Re	The lav	то						autopsy perform	ed? pri	or to completion of cause of ath?
ita		BeC	25. Was case referred to medical				26. Place	1 Yes 2 Death <i>Check onlone</i>		Yes 20 No
of V	Physicien: this certific	To	examiner?	pital: 1 ☐ Inpatient 2 ☐ I	R/Outpatient	3□ DOA Other	4 Nursin	g Home 5 Resider	nce 6 Other	(Specify)
n c	ding P h. After t funera	on:	27. Manper of Death 1ª ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe how	w injury occurred	d
isic	Vttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	00. 51.			s 2 No	1001		
Division	I or Atten after deat Director: I in by the	Certification:	4 Homicide determined	 Place of Injury - At ho building, etc. (Specify 	me, tarm, stre	et, ractory, office		City or Town,	State)	or Rural Route Number,
	Hospi 4 hou Funer iely fill	edical C	29a. Certifier (Check only one)	an: To the best of my know : On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the time	, date and pl nion, death o	ace, and due to the car ccurred at the time, da	use(s) and manr te and place, an	ner as stated. Id due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	And manner stated.		29c. License r	number	29	d. Date signed ((Month, Day, Year)
•	K		Jasuelle 1	Jalella	L-	D28	1222		7/2	2/05
	10	,	30-Name and address of person who com	eleted cause of death (Item	23a) (Type, P	Print) Page	11	10012	AL	Leen Mi
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure a	Itke	1/2	14/17/1	1,0	2155
	Sta Registr	-	.1111 2 6 2005	37 Registrar's Signat	600	de				2120
2111	MH 17 Pov 1/0/		001							

State of Maryland / Department of Health and Mental Hygiene

		(ertificate of l	Death	Reg. No.	5 24368
Dhariston	Decedent's Name (First, Middle, Last)			2. Dete o		3. Time of Death
Physician /Medical		AMILTON		July	23 20	05 6:00 AM
Examiner	4a Fecility Neme (If not institution, give street end	number)	4	b. City, Town, or Location of C	eeth 4c. County	of Deeth
	St. Joseph Nursing Hom		I Williams A Vana	Catonsville	Balt:	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. lest birth) 90 Yr	Months Davs	Hours Min. 8. Date of (Month) May	Birth Day, Year) 29, 1915	9. Birthplace (State or Foreign Country) Maryland
pu ≱_	Usuel Residence of Decedent 10a. Stete 10b. County	10c, City, Town o	or Location			10d. Inside City Limits
faho or	Maryland Baltimore	Caton	sville			1 ☐ Yes 2 No
the 28s.	10e. Street end Number	Caron	10f. Zip Code		10g. Citizen of V	Vhat Country?
3a or	145 Longview Drive		21228	}	USA	
me 2	11. Maritel Status 12. Was D	ecedent Ever in U,S.	13. Was Decedent of H	spenic Origin? (Specify Yes o		e - American Indian,
iges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Heelih and Mental Hygiene. If of Heelih and Mental Hygiene. If heelihen 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Exeminer must be notified at or other traumatic avant, the Medical Exeminer must be notified at or other traumatic avant, the Medical Exeminer must be notified at	1 Never Merried 2 Married 1 Yes.	Forces? es 2 (XNo Give or Dates:	1 ☐ Yes 2 ☐ No	n, Mexican, Puèrto Rican, etc. Specify:	Specify	ck, White, etc. White
2 ho	15. Decedent's Education (Specify only highest grede complete	16e. D	Decedent's Usual Occup	ation	16b. Kind of B	usiness/Industry
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1 end 2 Health em 27 I	Elizabeth Debaugh-Stone		Disposition (Name of	Channel; Elli		City or Town, State
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ertment ortant: Injury	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	New Ca	22. Name end Addres	-	Dareine	ne, maryland
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	23a. Pert1. Enter the diseese, or complications the shock, or heart failure. List only one cause of	at caused the death. Do no	t enter the mode of dyin	g, such es cerdiac or respirato	ry errest,	Approximate Intervel Between
Physician	1 /					Onset end Death
/Medical	Immediate Ceuse (Final disease or condition	proclectic L	unsout	an Discare		years
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be experience buries	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initleted events					
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	d					
The law requires that the deeth cersie has been signed by the ettending page 2 should be deteched for use Completed by Physician/N				and a David	Did tabasas usa as	ntribute to the cause of death
the d y the sched	Part II. Other significant conditions contributing to	aeath but not resulting in ti	ne underlying cause giv-		Dig tobacco use co 1 □ Yes 2 ☑ No	3 Probably 4 Unknow
y PI					12 105 22 100	3 Troubles
luires n sign uld be					Was an autopsy	24b. Were autopsy findings available prior to
w require been sign should t					performed?	completion of cause of deeth?
The lev ste hes pege 2					I□ Yes 2₽No	1 ☐ Yes 2 ☐ No
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Physician: this certific rel director,	examiner?	☐ Inpatient 2 ☐ ER/Outp	petient 3 DOA Oth			er (Specify)
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Attending or death. • ctor: After by the fune iffication	1 ✓ Neturel 5 ☐ Pending (M 2 ☐ Accident investigation	fonth, Day Year) Inju		Yes 2 □ No		
er de ecto by th	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ple	ece of Injury - At home, farm	n, street, factory, office		on (Street and Numb Town, State)	er or Rural Route Number,
tal or Attanding Pissefter death. al Director: After tied in by the funere Certification:		namy, etc. (opec.)				
To the Hospital or Attending Ph within 24 hours abter death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 1	29a. Certifier 1 Certifying Physician: To the (Check only one) 1 Medical Examiner: On the and m					
within of the omple	29b. Signature end title of certifier		29c. License	e number	29d. Date signe	d (Month, Dey, Year)
⊢ ≯ ⊢ ŏ	CROVER RAVIEW ON		024	281	July 2	3 2005
. 2	30. Name end eddress of person who completed or	ause of deeth (Item 23a) /T	vpe. Print\		0	
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State	31. Dete filed (Month, Day, Year) 32	egistrer's Signeture	1			
Registrar	1111 2 6 2005	DOE PINE LEE O	parte			

DHMH 16 Rev 6/95

ORIGINAL

			1 - For Amend It	State em 6&10 f	e of Ma per	aryland/[fh G845	Depa Cei	artmept of F 26-05 tag tilicate of	lealth a Death	and Me	ntal Hyg	giene Reg. N e S	000	010
	Physici	an	1. Decedent's Name (First, Min	ddle, Last)	*				-		. Date of Dea		005	2. Time of Death
	/Medic	al	MARIE 4a. Facility Name (If not institu		ARGOT	•		HAENDLI 4b. City, Town, o			IULY	20	2005 County of Death	12:40 A M
	Examin	er	HOSPICE OF BA	-		RIST CT	R.	4b. City, Town, C		ISON		BALTIMORE		MORF
	Funeral Director		5. Social Security Number 100-12-8103	6. Sex	7. Ag	e (In yrs. last bir 94	thday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. 8	Date of Birt (Month, Day 3/07/1	911		place (State or Foreign htry) GERMANY
	/land ow		Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. City, Tow	n or Lo	cation					1	0d. Inside City Limits
	e Man	Director	MD	N/A		BALT	I MO	RE						1 Yes 2 □ No
	with th		10e. Street and Number 6403 DORAL D	DIVE ADT	D			10f. Zip Code	21	215		10g. Citi:	zen of What Cour	ntry?
	death	Funerai	11. Marital Status	12. Was	Decedent	Ever in U.S.	13.	Vas Decedent of H			fy Yes or No-		U.S.A. 14. Race - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or tems 23e or 28e-f show event, the Mudical Exercities must be notilined at	þ	1 ☐ Never Married 2 ☐ N 3 🕅 Widowed 4 ☐ Divord	larried 1 🗆 Y	d Forces? es 2 (7) h Give or Dates:	No		Yes 24 No	Specify:	i, Puerto Rio	can, etc.)		Black, White, Specify: WH	etc. ITE
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212	d within giene.	Completed	Elementary/Secondary (0-12	2) Colle	ge (1-4or 5			RIETOR	-/			DRE	ESS SHOP	
and		Be	17. Father's Name (First, Midd	le, Last)		EDIEDI	B NID				First, Middle,			
ary le	s 1 and 2 should be f Health and Menta item 27 Is markad othar traumatic ev	ဥ	MORITZ 19a. Informant's Name/Relation	nship (Type, Print)		FRIEDL/		g Address (Street	ANN and Numbe		Route Numbe	r. Citv or	Town State Zin	BRAVER Code)
	is 1 and 2 of Health ar item 27 is other trace		HENRY HAENDLE	R / SON				AMY LAN						,
Baltimore,	m 0 -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic		rom State	20b. Place of cemeter	f Dispo ry, crer	sition (Name of natory or other plac	ce)	Dat	θ	20c. Lo	cation - City or To	
İ			' 4 □ Donation 5 □ Other 21. Signature of Puperal Servi			CHEVRA		VAS CHES Name and Addre	,	7/24/			ALLSTOWN	- -
ã	permit. Departr Imports any inje		1 Jana	/	_			00 REIST		20L	LEVINS AD - P	ON 8	BROS.,	INC.
			23a. Part1. Enter the disease, shock, or beart failure. L	or complications the complications to the complications of the complex of the com	nat caused on each lir		not ent	er the mode of dyin	ng, such as	cardiac or r	espiratory an	rest,	771666	Approximate Interval Between Onset and Death
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В	Examiner		Sequentially list conditions,	b	3 to (or as	a consequence	oij.							
	ed ssit	niner	if any, leading to immediate Cause (Disease or injury	Due	e to (or as	a consequence	of):						1.5	· · · · · · · · · · · · · · · · · · ·
Ć,	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	c	e to (or as	a consequence	of):							
68760,	ificate be executed g physician and as the burial-transit	edicai		d										
			IF FEMALE:	23c. If yes	outcome	of pregnancy								
.O. Box	requires that the death cert een signed by the attendin hould be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Li 4 □ P	ve birth	2 Fetal death time of death		Ectopic pregnancy Other (specify)	'			2	3d. Date of delive Month	Day Year
<u>α</u>	es that the digned by the be detached	by Ph	Part II. Other significant cond	itions contributing	to death b	ut not resulting in	n the ur	derlying cause giv	en in Part I.		23e. Did to	bacco us	se contribute to th	e cause of death?
ords	w require been sig should b										1 □ Y	es 21	No 3□ Prob	abiy 4 Unknown
Records,	e law has b	Completed									24a. Was a autops	sy	24b. Were autor prior to con death?	osy findings available inpletion of cause of
Vital	sician: Th certificate rector, pag	Be Co	25. Was case referred to med	cal					26. Place	of Death (1 ☐ Yes Check only or	med? 2 X No	1 ☐ Yes	2 No
of V		ToB	examiner? 1 ☐ Yes 2 No		I ☐ Inpatie				er: 4 ☐ Nur		5 ☐ Resid		Other (Specify	Hospice
	ding F h. After funera	tion:	27. Manner of Death 1 Natural 5 Pen 2 Accident inve		ate of Injui Month, Day		rime of njury	28c. Injun Worl	yat k? Yes 2 ⊡ N		d. Describe h	ow injury	occurred	
Division	er dea rector by the	Certification;	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. P	lace of Inju	ury - At home, fa	ım, str	eet, factory, office	3 872		Location (S City or Town		Number or Rura	l Route Number,
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	To th withir To th comp	Me	29b. Signature and title of cert	fier	.1	:()		29c. Licensi	e number		2	9d. Date	signed (Month, L	Dey, Year)
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0	20		30. Name and address of pers	on who completed	cause of de	Bath (1967) (Туре,	· ·			rles S	tree	t	
	Sta Registr		31. Date filed (Month, Dey, Ye	£ 2005	2 Aegistra	ar's Signature	Sp	relis	'owson	, ₩D .	<u> </u>	-		

Haendler, Marie Marie Madoscla: 40AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#31,perDVR, C845,7/26/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** 1036 07 M. Dero-thy 24 2005 /Medical 4a. Facility Name (If not-institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mercy (enter Medical USA MD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country). Virginia **Funeral** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛣 F Months Days Hours 226-34-0600 Yrs. Director 75 06-23-1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic avant, the Medical Exercit er must be notified at 1 Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? TISA 1701 W. Lexington Street 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>~</u> Specify: 3 XWidowed 4 □ Divorced Black Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avent, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 6 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jessie Daughtery Alberta Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Midheights Road Baltimore, MD 21215 Valerie Herbert/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-28-05 Woodlawn Cemetery Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility ula Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as) consequence of): Enysician /Medical Examiner Acufe seval Sequentially list conditions, if any, leading to immediate cause. East of durying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The faw requires that the death certificate be executed attending physician and if for use as the burial-transit Due to (or as consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: N/A 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown N/A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No 2 No 1 Yes 1 Yes tha Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 28f. Location , Street and Number or Rural Route Number, City or Town, State) Diractor: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number TA CHANG W.D 7/24/05 serson who completed cause of death (Item 23a) (Type, Print) 30. Name and address CHANG chase Street #311 TA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Elever it Sparke

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Completed

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Examiner

Physician/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or itan any injury or other treumaits.

Physician /Medical

Examiner

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the

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital |

death.

To the Hospital or Attency within 24 hours effer death To the Funeral Director;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Deal

th	F	Reg. No2 (005	24
,	2. Date of Dea Month	ath Day	Yeer	3. Time

0345

23d. Date of delivery

JACKSO N	July 24	4, 2005
b. City, Town, or Location of Death		4c. County of Death
		2 .

Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Monthel Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days 26 212-96-7492

Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No

MARYLAND 10g. Citizen of What Country? 10e. Street and Number USA

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No 3 Widowed 4 Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 00

18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last)

NTHONI WINFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(STEPHOTHER EVELYNS GWYNN OAK

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

ZION CEMETERY 07-29-05 LANSDOWNE, M.D. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pagitiv BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD, 21217 21. Signature of Funeral Service Licensee

retuc.

Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finat disease or condition resulting in death) Wound Gunshot Due to (or as a consequence of):

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant

3 Ectopic pregnancy

in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a Was an

Completed 1 Yes 2 🗆 No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one)

Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 2 XER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 17,4 1 Natural 5 Pending 1 Yes 2 No investigation 24/05 2 Accident

Subject Shet

Location (Street and Number or Rural Route Number,
City or Town, State) 4100 Fir Man Ave 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Baltimore

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2x Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OCME July 24, 2005 wo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 ALL AROL My H

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 For State of		artment of Health and N	Mental Hygier	ne	
			Registrar	Ce	ertificate of Death	Reg. I	2005	24373
	Physici	an a	1. Decedent's Name (First, Middle, Last) Branden	John	2560	2. Date of DeathMonth	Day Year	-4 IS DM
	/Medic		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Death	July 2	4c. County of Deat	h
	Examin	er		spital	Baltimore City	1		
24	Funeral Director		5. Social Security Number 6. Sex/	7. Åge (In yrs. last birthday Yrs.	f Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea (0 · 1 · 19)	9. Birt	hplace (State or Foreign funtry) ARV AND
	Đ		Usual Residence of Decedent	100 City Town and		10 116	$\mathcal{W} = \mathcal{W}$	incy and
	ours after death with the Maryland rel', or Items 23s or 28e-f show Exertiret rust Le notified at	jor	10a. State 10b. County	10c. City, Town or L	TMORE			10d. Inside/City Limits 1 1 Yes 2 □ No
	th the or 28e.	Funeral Directo	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	ountry?
	s 23£	ral	2703 E. CHASE	STREET	21213	3	U.S.A	7.
0	r Item	Fune	1 Never Married 2 Married 1 Yes	2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	e, etc.
5-0036	72 hours after "naturel", or Ite	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	ates:	1 ☐ Yes 2 ☑ No Specify:	100	Specify:	LACK
<u>-</u>	within 72 ho ene. then "natur	plete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring 16b.	Kind of Business/	Industry
717	filed with Hygiene other the	Completed	12th	401 37)	STUDENT	(F:		ENT
and	ed day	To Be	17. Father's Name (First, Middle, Last)	WON, JR.	18. Mother's Nam	e (First, Middle, Maid H) RUI	91 Sumame) SIN SON	
Mary	2 should and Men Is marke sumatic	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number or Rut			
	s 1 and 2 if Health item 27 I	3	BCH, A. KOBINSON (A	10THER 270	3 E. CHASE St.	BATTIMOKE Date 20c.	MD 2	21213
altimore,	e = = =		1 Darial 2 □ Cremation 3 □ Removal from 5 '4 □ Donation 5 □ Other (Specify)	State KING ME	ematory or otner place)			
alti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Servis Licensee	7170-9 748	MORIAL PARK 7.22. Name and Address of Facility Par	Alba C. AK	EONE FUN	erretione
n	88 11 12 13		Daugh freene	- 4	905 YORK RIMO	BATIMON	RE, MAX	CYLAND 21212
			Part1. Enter the disease, or complications that constructions that constructions are the shock, or heart failure. List only one cause on example the construction of the construction	aused the death. Do not er ach line.		or respiratory arrest,		Approximate Interval Between Onset and Death
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8	Examiner	L	Sequentially list conditions, b.					
	uted I Insit	Examine	cause. Enter Underlying Cause (Disease or injury	or as a consequence of):				16
oʻ	cate be executed bhysician and the burial-transit		that initiated events c	or as a consequence of):				
9/8	cate be physici the bu	dical	d					
Box 6	leath certific attending p	n/Me		come of pregnancy			23d. Date of del	ivery
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rds	w requires been sign should be	ed by				1 🗆 Yes	2.2 No 3 □ Pr	obably 4 Unknown
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ס ר	<u>r</u> ≠ <u>r</u>	-	27. Manner of Death 28a. Date	of Injury h, Day Year) 28b. Time Injury		28d. Describe how in		any)
SIO	Attendir death. ctor: Af y the fur	catlc	2 Accident investigation		M 1 Yes 2 No			
Division of	after d Direct Jin by	Certification:	determined 289 Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Hu lite)	irai Houte Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C		asis of examination and/or i	ath occurred at the time, date and place, nvestigation, in my opinion, death occur			
	Fo the within 2 Fo the comple	Mec	29b. Signature and title of certifier	ier stateu.	29c. License number	29d. [Date signed (Monti	h, Day, Year)
			May 8.		RES-000	Ju	14 25	2005
			30. Name and address of person who completed caus Megan McCabe 600	e of death (Item 23a) (Type	St. Baltimor	e, MO	वायम	7.
	Sta Registi		91 DatMillor (Month Day Year) 1 32 48	egistrar's Signature	Carelis			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

Physician 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner It anove Kehabilitation Extended Care Baltimore If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday)
Yrs. 5. Social Security Number **Funeral** 10 M 2 F Days Hours 248.22.2069 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the Araked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be event. 10a, State 10b. County 10c. City, Town or Location ACTIMORE by Funeral Director 10e. Street and Number 10f. Zip Code 5530 as Decedent Ever in U.S. med Forces? WYes 2 \(\square\) No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Quban, Mexican, Puerto Rican, etc.) 1 Never Married 2 M Baltimore, Maryland 21215-0036 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) I RANS PORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ACKSON SIHON DEULAH ပ္ 19a. Informant's Name/Relationship (Type, Print) ELLIOH MKWOOD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) **≸**Burial 2 ☐ Cremation 3 Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final malignant **Physician** disease or condition resulting in death) /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No Be Completed autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 No Certification: To 1 Tyes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Manger of Death 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide withir 24 hours a To the Funeral D 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 34359 (OHIO) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John S. Lah, M.D. 3900 Lock Raven Bonfevard, Baltimore, maryland
31. Date filed (Month, Day, Year)

JUL 2 6 2005

June 1 June 1

6:43am. 05 4c. County of Death 8. Date of Birth (Month, Day, Year)

VINE 24,199

South Birthplace (State or Foreign
 Country) 10d. Insige City Limits 1¥ Yes 2 No 10g. Citizen of What Country? Black, White, etc. ACK 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAKYLAND ZDOG OWINGS MILLS, MD 22. Name and Address of Facility VAUGH C. GREENE TWERN HOME ROTO BAUTIMORE, MARYLAND 21212 Approximate Interval Between Onset and Death unknown 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 TYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 05-04896 Dante Jordan RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

LE	JULUAII		Fair	State of Maryland / Dep	partment of Health and N	Mental Hygier	ne	
			1 - For State Registrar	· · · · · · · · · · · · · · · · · · ·	ertificate of Death	Reg. I		
	0 00	76	Decadent's Name (First, Middle, Last)		Timodio or Dodair	2. Date of Death	"2005	A. Three of Deaths
*	Physici	an	Danto	Torder		Month E	2005	02/2 A M
1	/Medic		4a. Facility Name (If not institution, give s	Street and number)	4b. City, Town, or Location of Death	July 20,	4c. County of Death	0242 A. M
4	Examir	ier	Johns Hopkins Hosp		Baltimore		ic. county of boats	,
100	-	~	5. Social Security Number 6. Sex			8. Date of Birth	9 Rint	nplace (State or Foreign
	Funeral Director			(M 2□F 7 (Yrs.	Months Days Hours Min.	Month Day Yea	40 8	T'T
27			Usual Residence of Decedent	24		10-20-		
	yland		10a. State 10b. County	10c. City, Town or L	Location			10d. Inside City Limits
	Mar	to	MD	'Ralt	imore			1 Yes 2 No
	n the	ie	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	untry?
	h wit	a D	725 8. 22NE	Street	21218		USA	
	hours after death with the Maryland turst', or Itams 23s or 28s-f show at Exercition to profitted at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Amer	
9	after or Its	E	Never Married 2 Married	1 Tes 2 Total		nicari, etc.)	Black, White	o, etc.
21215-0036	ours	1 by	3 Widowed 4 Divorced	Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	ack
5	72 h 'netu	Completed	15, Decedent's Educ (Specify only highest grade	cation 16a. Dece	edent's Usual Occupation e kind of work done during most of work	ing 16b.	Kind of Business/l	ndustry
21	ithin	id u	Elementary/Secondary (0-12)	College (1-4or 5+)	DONOT use retired)	1	1000	
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100	be fit Ital H Id otl	Be	17. Father's Name (First, Middle, Last)	0 ,	18. Mother's Nam	e (First, Middle, Maid	an Sumame)	
$\frac{1}{8}$	ould Men Marke Marke	မ	neuro Jorg	lan	MICH	elle	Jone	S
Maryland	2 sh and lerr		19a. Informant's Name/Relationship (Ty)	26, Print) / 19b. Mail	ling Address (Street and Number of Rur	al Route Number, City	r or Town, State, Z	
-	l and lealth im 27 her t		MICHELIN	20b. Place of Disp	64 mm00D1	Ka Du	140 MI	212/8
Ö	Pages in hent of Heart of Heart of Heart in hear		20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ R	emoval from Stale	ematory or other place)	20c.	Location - City or 1	own, State
Ë	men tant: jury		4 ☐Donation 5 ☐ Other (Specify)	Heasa	of Kest 17/2	250/2	altin	one, MD
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "netural", or itams 23s or 28a-f show apprigning or other treumatic event, it a Miccipal Examination and profile at ance.		21. Signature of Funeral Service License		2. Name and Address of Facility	rue Fry	essal 6	services
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er a			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not en ne cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Gunshot Wou	uds(2) of Ches	t and A	rm	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	04.50			
п	Examiner		Sequentially list conditions					
	D #	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
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Ő,	e exe		resulting in death) Last	Due to (or as a consequence of):				
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Вох	uires that the death certific signed by the attending f d be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deliver Month	very Day Year
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Θ.	hat the d by letac	F.	Part II. Other significant conditions con	tributing to death but not regulting in the	underhine enun muse in Dart I	22a Did tabasa		the accept of death 2
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			h Check only one		
Ž	ys dir	ပ္	1 ZYes 2 No	ospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence	6 □Other (Spec	ify)
<u> </u>	ding P h. After t funera	Ë	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b. Time of Injury Injury	Work?	28d. Describe how in	jury occurred	
Si.	Attending r death. octor: After by the fune	cati	2 Accident investigation	7/20/05 2:18.	1 □Yes 2 DNo	Subjec	t shot	
Division of Vital Records,	or Attendent efter death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rui ^{Me)} 200 BLI	al Route Number,
	urs e		, ,	Street		St- Ba	etimore	2 MD
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edicai	(Check only 2 Medical Examin	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in	ith occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	the the mple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number			
	7.¥7.8		D LA 2 P E	A 20.	O.C.M.E.		Date signed (Month, y 20, 200	
	(· Carcor of	illan Ma				
			A M. M. A. 11 Man	mpleted cause of death (Item 23a) (Type	^{o. Print)} 111 Penn Stree	t, Baltimo	re Maryla	and 21201
2016	×		31. Date filed (Month, Day, Year)	B2 Registrar's Signature				
	Sta Registr			302. Registrar's Signature	E)			
27		= 4	JUL 2 6 2865	Latinon 20 17				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JULANITA JARVIS July 20 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner Hark Jill S. Date of Birth (Month, Day, Year)
April 7, 192 Bothway Cline Sis Nursm imber 6. Sax 7. Age (In yrs. Ta Itimore Ba Facili 5. Social Security Number 7. Age (In yrs. Tast birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/0XF Director 218-16-0878 80 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other then "natural", or Itema 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland Director N/A Baltimore 1 ves 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3832 Elm Avenue 21211 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes XX No Specify: Specify: white XX Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Operator 12 Sweetheart Cup 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bryce Greene Adrianna ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st. Department of Health and important: if Item 27 is m Rolan G. Crowther Son 3832 Elm Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lake View Memorial Pk 7/23/2005 ö 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) any injury Name and Arress of Faculty Burger-Henss-Seitz Funeral Home, Inc. 3031 Falls Road Daltimore, Maryland 21. Signature of Funeral Service Licensee Pint 1. Enter the dilease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final 21211 Approximate Interval Betweer Immediate Cause (Final Onset and Death **Physician** 1 de disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualty (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physicien and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 1 Yes 20 completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred or Attending Natu al 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitai within 24 hours a Leadifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndidi Feinser Good Samaritar 31. Date filed (Month, Day) 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	State of Maryla		artment of H rtificate of I		-	giene	005	243	77
*5,1		1. Decedent's Name (First, Middle, Las	1)				2. Date of De.	ath		3. Time of	Death
Physicia /Medica		Helen Elizabeth	Jarvis				07	Day 21	2005	4:33	РМ
Examine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Death		
	P	Gilchrist Hospice	2		Towson			Ва	ltimore		
Funeral		5. Social Security Number 6. Se		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (State o	or Foreign
Director		213-20-2336	□M 2√F 79	Yrs.			(Month, Da 11-26-	-1925		yland	
and *	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	10d. Inside Ci	ity Limits
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28a-	오上	10e. Street and Number	.e woo	Julawn	10f. Zip Code			10g Citize	on of What Cou		
Sa or		1121 Daniels Aver	W10		21207					y.	
death	Funeral	11. Marital Status	12. Was Decedent Ever in t		Was Decedent of H	ispanic Origin? (5	Specify Yes or No	U.S.	A I. Race - Ameri	ican Indian,	
after or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		If Yes, specify Cuba		rto Rican, etc.)		Black, White	etc.	
hours at	2	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:		1∐ Yes 2⊠ No	Specify:		S	Specify: Wh	ite	
72 ho	Completed	15. Decedent's Ed (Specify only highest gra-			dent's Usual Occupa		orking	16b. Kind	d of Business/Ir	ndustry	
iffin a	<u>a</u>	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)					
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ore, Maryland Z IZ ID-0050 Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural," or itame 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at	-	Mildred A. Jarvis 20a. Method of Disposition			Daniels Disting (Name of	Avenue v	Date Date		y Land 2 ation - City or T		
nt of nt of nor		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other plac	,					
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A CONTRACTOR	+	23a. Part1. Enter the disease, or comp	plications that caused the dea	ath Do not en	1630 Edm	ondson A	Avenue Ca	tons	ville,	MD 212 Approximate	
		shock, or heart failure. List only of	one cause on each line.							Interval Bet Onset and I	ween
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ath cer ttendir	2	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	☐Ectopic pregnancy			23	d. Date of deliv Month	•	Year
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vital mecords, r.O. box o sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as		Part II. Other significant conditions co	notobuting to death but not re	eulting in the u	nderhing cause and	on in Part I	23e Did to	abacco use	contribute to	the cause of d	loath?
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The structure of the st	Ö	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	f 28c. Injury Work M 1 🗀	<br Yes 2 □ No					
or Attending effer death. Director: Affer in by the fune	E	3 Suicide 6 Could not be determined	289. Place of Injury - At I	nome, farm, sti	reet, factory, office		28f. Location (S	Street and	Number or Rur	al Route Num	ber,
s effe	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Tov	m, State)			
hour hour unar		29a. Certifier Check only 2 Medical Exam	ysician: To the best of my kn	owledge, deat	h occurred at the tim	ne, date and plac	e, and due to the	cause(s) a	nd manner as	stated.	
To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: Affer this: completely filled in by the funeral dir	Medical	0.107	iner: On the basis of examin and manner stated.								
To To	2	29b. Signature and title of certifier	1.1	mo	29c. License	number		29d. Date	signed (Month,	Day, Year)	-
1		1/ stroke	in ling!		Day	XV.3		JUL	721,	2003	,
5		30. Name and address of person who d	ompleted cause of death (Ite	m 23a) (Type,	Print)	1.1.0	7 2 2	fn 10	10 21	2055	
7 0		31. Date filed (Month, Day, Year)	20 Philipping Sinn	C 6/	01 14.00	28-US D.	T Jack	0. 11	21	~ -/	
State	6		005 Reserve	H /	marke 3						

		_ For	State	f Mary	land / Dep	artment of	Health and	Mental Hygi	ene	
		1 - State Registrar			Ce	rtificate o	f Death		g. No 2005	24378
Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	
/Media		Georgia E. Jowers 4a. Facility Name (If not institution, g	rive street and nu	mber)		4b. City. Town	n, or Location of De	- Fully	20, 2005 4c. County of De	
Exami	iei	Union Memorial Hospi		,		Baltim		<u> </u>	NA	
Funeral		5. Social Security Number 6	Sex 1 □ M 2 XX F	7. Age (In	yrs. last birthday)	If Under 1 Ye Months Day			Year) 9. B	irthplace (State or Foreign Country)
Director		212-34-9846 Usual Residence of Decedent	1 W 22626		69 Yrs.			12-25-193		h Carolina
yland how		10a. State 10b. County		100	c. City, Town or L	ocation				10d. Inside City Limits
e Mar	ctor	MD NA			Balt	imore				1 X Yes 2 □ No
with the	Funeral Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	Country?
leath ns 23	erai	2115 Sidney Avenue	12. Was Dec	edent Ever	in U.S. 13.	Was Decedent		(Specify Yes or No.	USA 14. Race - Am	neocan Indian
after of the relative of the r		1 Never Married 2 Married	Armed F	orces? 2 X No				(Specify Yes or No- erto Rican, etc.)	Black, Wh	
13-0030 172 hours after death with the Maryiar "natural", or items 23e or 28e-f show calcul Ever in art he rediffed at	d by	3 Widowed 4 □ Divorced	If Yes, G Year or I	ve ates:		1 ☐ Yes 2 X ☐ N			Specify: Bla	nck
in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Oct kind of work do DO NOT use ret	ne durina most of w	vorking 1	6b. Kind of Busines	s/industry
d with giene	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	,		Domesti	c
be filed within 72 hours after death with the Maryland lal Hygiene. Id other then "naturel", or items 23e or 28e-f show event, tre Medical Everalisationals in Medical Everalisations.	Be	17. Father's Name (First, Middle, La	st)				18. Mother's N	lame (First, Middle, M	aiden Surname)	
y Id	은	Frank Code	CF Dried				Mary			
INICAL Initial Initial Initial Initial Initial		19a. Informant's Name/Relationship Sherry DeCosta/ Step						Rural Route Number, e, MD 21229	City or Town, State,	Zip Code)
s 1 ar of Hea item		20a. Method of Disposition		- 1	Ob. Place of Dispo			-	Oc. Location - City o	r Town, State
Pages tment of tent: If it		1 ☐ Burial 2 XCremation 3 `4 ☐ Donation 5 ☐ Other (Spe			Metro Crem		07-2	6-05 Ca	atonsville,	MD
perfull December 1 Mary I will be filed within 72 hours after death with the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene importent: If item 27 is marked other then "natural; or items 23a or 28e-f show any in ury or other treumsitic event; if we Medical Everginational by rectifical any once.		21. Signature of Funeral Service Lie	ensee	\supset		2. Name and Add				
40380		23a. Part1. Enter the disease, or co	molications that	raused the				N. Gilmor St		21217 Approximate
Physician		Immediate Cause (Final	ly one cause on	ach line.	,		1 1		31,	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. End Due to	(or as a co	nsequence of):	lenal	ause	ase		10 years
Examiner		Sequentially list conditions.	b. He	1.DO	tensi	on				20 years
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	∵ue to	o as a co	nsequence of):	mall	E.c.			10 years
execu n and lal-tra	Exar	that initiated events resulting in death) Last	c. Due to	(or as a co	nsequence of):	Nelli demi	TILL			10 9 2013
cate be executed cate be executed obysician and the burlal-transit			aH	ype	Missia	lemi	a.			loyears
The color us, F.C. but on the law requires that the death certificate be executed the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	22. 1/	. ,						
eath c attend for us	cian/	23b. Was decedent pregnant in the past 12 pronths?			Fetal death 3	□Ectopic pregna			23d. Date of de Month	elivery Day Year
oy the ached	hysid	1 ☐ Yes 2 T No 9 ☐ Unknown	9□ Unkr		or doaling 5	1 Other (specily)				
iries that the death certific signed by the attending p do de detached for use as it	by P	Part II. Other significant condition:	s contributing to a	eath but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
w requires the requirement of							· · · · · · · · · · · · · · · · · · ·	1 Tes	2 No 3 F	robably 4 Denknown
e law has b	Completed							24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
	e Co	25. Was case referred to medical						1 ☐ Yes 2	ZNo 1 ☐ Ye	
Or VII.al not Physician: The la this certificate has ral director, page 2	0 8	examiner?	Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA		eath <i>(Check only one</i> Home 5☐ Resider		ecify)
ding Ph th. After th funeral	on: T	27. Man of Death 1 Matural 5 Pending	28a, Date		ar) 28b. Time o	f 28c. In	ijury at Vork?	28d. Describe hov		,
l or Attendin after death. Director: Af	Certification:	2 Accident investigat 3 Suicide 6 Could no	he	and Indiana	AA baara 62		☐Yes 2☐No	206 1		
after after Direct In by	ertif	4 Homicide determine	ed 289. Place build	ing, etc. (S	At home, farm, st pecify)	reet, factory, office	20	City or Town,		Rural Route Number,
ospita hours unerel ly filled		29a. Certifier 12 Certifying	Physician: To the	best of my	y knowledge, deat	h occurred at the	time, date and pla	ce, and due to the car	ise(s) and manner a	as stated.
To the Hospital or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Aedical	one)	and mar	ner stated.	mination and/or in			curred at the time, dat		
To To	Σ	29b. Signature and title of certifier	001	C N	ND	29c. Lice	mse number T 2 U 3	8946	d. Date signed (Mor	nin, Day, Year)
ha		30. Name and address of person wh	o completed cau	se of death	(Item 23a) (Type	Print)	1 2 1 2	0/10	July	1,2005
7		Taraneh	mer	ran	ii, Mi	(M	ion n	nemorial	! Hospir	LO, 2005 Hal, MD.
Sta		31. Date filed (Month, Day, Year) JUL 2 6 2	005	Registrar's S		and D				
Regist	air	JUL 4 0 4	UUJ MA	BOKE	15 43					

DHMH 17 Rev 1/2001

Registrar

JUL 2

6 2005

State of Maryland / Department of Health and Mental Hygiene Reg. N& 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2005 2:20 P_MM 19 July George Edgar Kimball, Jr. /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Milford Manor Nursing Home Pikesville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | February | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 1932 | 193 7. Age (In yrs. last birthday). 5. Social Security Number 217-24-5939 **Funeral X**□ M 2□ F Months Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ehow the Medical Examinational be molified at 10d. Inside City Limits Maryland Carroll Westminster 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Tremont Drive #12 21157 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√2 Yes 2 No If Yes, Give Year or Dates: 9 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 🎖 ☐ No Specify: þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) \$heet Metal Worker Coast Guard year othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any liqury or other traumatic event gnes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George E. Kimball, Sr. Myrtle Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4028 Paige View Rd Randallstown, Md 21133 Jeannine C. James/Daughter Baltimore, Commetery, crematory or other place)

Garrison Forest Vet. Zem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Ealtimore, Md 21215 Takin 23a. Part | Enter he dis se, or complications that caused the complex of the failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 DM or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: P Nursing Home 5 Residence 6 Other (Specify) ctor: After this y the funeral o 27. Manner of Death 1-2 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending Intury death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A completely filled in by the f investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 30. Name and odress of person cause of death (Item 23a) (Type_Print) 1838 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 2 6 2005

sean Kel	rog,	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F	Health and <i>Death</i>	d Mental Hyg	giene 0 S _{oo. No.}	05 2438
Physi /Med		Decedent's Name (First, Middle, La SEAN KELLOGG	st)				2. Date of Dea Month July	Day 24.	3. Time of Death 2005 07:55 A
Exam		4a. Facility Name (If not institution, given University Hospital)			4b. City, Town, o	or Location of De Baltimor	eath		y of Death
, Funera Directo		5. Social Security Number 6. S 132.74.8281 1. Usual Residence of Decedent	ex 7. Ag	ge (In yrs. last birthday) 27 Yrs.	Months Days	If Under 24 H Hours M		1977	Birthplace (State or Foreig Country) NY
e Maryland a-f show	ctor	10a. State 10b. County MD CAROLII	NE	10c. City, Town or L DENTON	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23a or 28	ai Director	10e. Street and Number 309 N. 6th ST			10f. Zip Code 21629		1		What Country?
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itema 23a or 28a-f ehow event, the Madical Engitler must be notified at	d by Funeral	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 224 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐ No	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Ra Bla Specii	ce - American Indian, ck, White, etc. fy: WHITE
BAITIMOTE, MATYIANG Z1Z13-UU30 semit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural, or any heliury or other traumatic event, the Medical Examination.	Completed by	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire OLICE OFI	during most of a d)	vorking		Business/Industry
aryland 212 should be filed within and Mental Hygiene. s marked other than umatic event, the M	To Be (17. Father's Name (First, Middle, Last) LESLIE KELLOGG					lame <i>(First, Middle, I</i> I BAKER	Maiden Sumai	те)
re, Maryla s 1 and 2 should Health and Mer Itsm 27 is merke other traumatic		19a. Informant's Name/Relationship (LESLIE KELLOGG	Туре, Print) FATH	19b. Maili IER 52	ng Address <i>(Str</i> eet 62 DWYER	and Number or LANE LA	Rural Route Number KE MARY, F	r, City or Town LORIDA	, State, Zip Code) 32746
Pages 1 ar Pages 1 ar nent of Hea nnt: If Itsm.		20a. Method of Disposition XIX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specification)	Removal from State	-	osition (Name of matory or other pla			20c. Location	- City or Town, State
Description permit. Page Department of Important: If any Injury or		21. Signal 6 of Funeral Service		Ť	INK FUNE	KAL HOME			
the death certificate be executed Wedgica The attending physicien and to use as the burial-transit	1	23a. Part 1. Enter the disease, or aom shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	.0 1 1	unshot u				Inierval Between Onset and Death
the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		1	ate of delivery onth Day Year
F 2 5 8	þ	Part II. Other significant conditions o	ontributing to death b	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	1	tribute to the cause of death? 3 Probably 4 Unknown
The law ate has b page 2 st	Completed						24a. Was all autops perform	y	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 □ No
- × × 0	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1X Inpatie			er: 4 🗆 Nursing	eath Check only on Home 5 Reside		ner (Specify)
ing ing	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ILLTIN	y Year) 28b. Time o Injury Found 7.0	A Wor	y at k? Yes 2 No	28d. Describe ho	swinjury occur 3hot 5	elf
i gift o		3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify) ŚĈŁNE			28f. Location (St. City or Town	, State) 3	per or Rural Route Number, N. Leth. Street
To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best liner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca	use(s) and ma	anner as stated. and due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier Auman Bouch	hall mo			e number ME	29	_	d (Month, Day, Year) 25, 2005
0	tate	30. Name and address of person who a Purvelu E Scrience (Month, Day, Year)	mall, my	eath (Item 23a) (Type, ar's Signature	Prin 111 Pen	n Stree	t Baltimo	ore, Ma	ryland 21201
Regis		HH 9 A	2005	£ø	Read .				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret Smith Keigler July 23, 2005 6:36AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 💢 F 215-30-2150 Director Dec. 21, 1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23a or 28a-f ehow 10d. Inside City Limits 1 ☐ Yes 2X No Directo Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Maplehurst Lane 21111 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home ith and Mental Hv. 7 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္က Robert Dixon Smith Margaret Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permi. Pages 1 and 2 Department of Health at Important: If Itam 27 is any injury or other trans George Keigler/Husband 1000 Maplehurst Lane Monkton, MD 21111 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servit Magazine Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Glioblastoma months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificete 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) N Spice 2 1 Yes 2 00 this After thi 27. Manner of Death 1 (2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: d in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide hours after within 24 hours a To the Funeral C 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 51926 2005 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Gordon 6565 N. Charles St Boltmare 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 6 2005 State Registrar

and 21215-0036

Maryl

Itimore,

Bai

P.O.

Division of Vital Records,

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28a-f show any injury or other traumatic event, the Medical Evanthal must be notified as

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

þ Completed Be Certification: To within 24 hours after death To the Funeral Director: filled in by the Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

1	SHEILA		1	EE					Month	22		'ear	4:26	Ам
,	4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		4b. City,	Town, or	Location (of Death		4	c. County of	Death	1	
	NORTH WEST		AL				ALLS				1,000		ORE	
	5. Social Security Number	6. Sex	7. Age (In yrs.		Months Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	av. Yea	r) 9	. Birthp	lace (State or	Foreign
	212-74-0167	1□M 3 / □F	49	Yrs.		, -	1100.0		June	12,	,1956	Ma	rylan	d
	Usual Residence of Decedent													
	10a. State 10b. County			y, Town or L								1	0d. Inside Cit	y Limits
2010	Maryland N	/A	Ва	ltimo	ore								1 X Yes	2 🗌 No
e	10e. Street and Number	Ant	. 3в		10f. Zip	Code				10g. C	itizen of Wh	at Coun	itry?	
ם מ	2958 Mosher C	ourt Apt	. 55		2	121	6				USA			
le	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	dent of H	ispanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race -			
2	1 Never Married 2 Marrie	ed 1 ☐ Yes	2 🔀 No						racan, etc./			White,	ack	
2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes	2X1 No	Specify:				Specify:	DI	ack	
ered	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wo	al Occup	ation	t of work	ina		Kind of Busin		,	
ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired	1)	t or work	y	Cor	opin :	Hei	ghts	Day
Ö	12th grade			Chilo	dcare	Pr	ovid	er		Car	re Cei	nte	r	
ט ט	17. Father's Name (First, Middle, L.	ast)					18. Mothe	er's Nam	e (First, Middle	, Maide	n Sumame)			
0 0	Louise Lee						Cha	rlo	tte E.	, Jo	ohnso	n		
	19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mail	ing Address	(Street	and Numbe	er or Rur	al Route Numi	er. City	or Town, Sta	ate. Zio	Code)	
	Charlotte Lee		r						altimo					207
	20a. Method of Disposition	,	20b. F	Place of Disp	osition (Nar	ne of	1				Location - Ci			
	1 ☑ Burial 2 ☐ Cremation	3 Removal from	State	emetery, cre	matory or o	ther plac		7/2	9/05				aryla	~ d
	*4 □ Donation 5 □ Other (Sp.		rrı	nity						Dui	luaik	, 1	aryıa	IIG
ŀ	21. Signature of Funeral Service L	icensee		2	2. Name ar	d Addres	ss of Facili	by Ch	atman-	-Hai	rris	Fun	eral	Home
	Deregt	Thurs		52	240 F	eis	ters	tow	atman- n Rd I	Balt	timor	e,M	d 212	15
	231. Fart 1. Enter the di Aas - or di shock, or heart for ure. List o	complications that only one cause on e	caused the deat	h. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,		- 1	Approximate Interval Betw	een
	Immediate Cause (Final		D STA	-									Onset and D	eath
	disease or condition resulting in death)	- a.	(or as a conseq		RUN	//IC	<i>ν</i> :	6 6 1	36			_		
		Due to	(Or as a conseq	uerice oi).										
_	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence off:								_		
	Cause (Disease or injury	50010	(or as a conseq	derice ory.										
a	that initiated events resulting in death) Last	c	,											
ũ	resulting in death, cast	Due to	(or as a conseq	uence of):										
20	•	d												
5		1								-				
178	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		75-1						23d. Date of	of delive	ry	
2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregr	oirth 2 ☐ Feta nant at time of d		⊒Ectopic pr ⊒ Other (sp						Month	i	Day Y	ear
2	9 Unknown	9□ Unkn	own											
_	Part II. Other significant condition	as contributing to d	eath but not res	ulting in the I	inderlying c	ause divi	en in Part I		23a, Did	tobacco	use contribu	ute to th	e cause of de	ath?

1 SHatural

2 Accident

3 Suicide

4 Homicide

MYLOMA

autopsy 2 No 26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

24a. Was an

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

2005

3 Probably

4 Onknown

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 27. Manner of Death

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 □ ER/Outpatient 28b. Time of Injury

3□ DOA 28c. Injury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

Pcertifying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) inanner stated.

JULY 22

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title.

6 Could not be determined

29c. License number M.D. P57722 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401 OLD COURT ROAD, RANDAUSTOWN MO 21133

State Registrar 31. Date filed (Month, Day, Year)
JUL 2 6 2005

EUNARD RICHARDSON

32. Registrar's Signature

			1 - State Registrar	State of	Marylan			nt of H te of L		ind M	ental Hyg R	jiene	000	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Elizabeth V. I		L						2. Date of Dea Month July	Day 23,	2005	4:45 A M
	Examir		4a. Facility Name (If not institution, give s Manor Care Nursiv			ille		, Town, or OSSVI		f Death			ounty of De Utimo	
-	Funeral Director		272 01 7130	7. M 2 7 F	Age (In yrs.	last birthday) Yrs.	If Und Month	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day April 1	, Year) , 191	9. B 5 Ma	irthplace (State or Foreign Country) LYLand
	e Maryland 3a-f show tiffed at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo'	ıe	10c. Cit	ry, Town or Lo	cation Uti	nore						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23 or 21		10e. Street and Number 9134 Simms Avenu	ie					21234			0g. Citize	u.S.A	•
980	72 hours after death with the Maryland Instural, or iteme 23a or 28a-f show Utsal Exacultative ust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? [XNo			edent of His ecify Cubar 2 X No	spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	ž.	Black, Wh	nerican Indian, lite, etc. White
21215-0036	within ane.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th Grade		or 5+)		lent's Us kind of v DO NOT 12MA	ork done d use retired)	ition uring most	of workir	ng	16b. Kind	of Busines	
Maryland 2	be de la participa de la parti	To Be C	17. Father's Name (First, Middle, Last) Godfrey Fishe						18. Mother		(First, Middle,	Maiden S Beck	umame)	
	s 1 and 2 should f Health and Mer ttem 27 is marks other traumatic		19a. Informant's Name/Relationship (Ty Mr. Charles Fisher			9134	Sú	nms Au		, Ba	l Route Number ltimore,	, MD	21234	
Baltimore,	m O		20a. Method of Disposition 1 Disposition 2 □ Cremation 3 □ R Donation 5 □ Other (Specify)	emoval from Sta	ate		natory o	other place uth (cem.	7/26,	/2005 1	Balti	imore,	or Town, State MaryLand
Ball	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License		2	9	705	Belai	r Rd.	., Ba	himunek Utimor	e, MI		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on eac	an line.	Hy(o	KIF	+			r respiratory arr			Approximate Interval Between Onset and Death
38760, /	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence as a consequence	uence of):	is str	uesi	ve !	u Ca	ONIXCY	שיין זע	A1E	
.O. Box 6	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ NO 9 □ Unknown		h 2 ☐ Feta nt at time of d	Ideath 3]Ectopic] Other (pregnancy specify)				23	d. Date of d Month	elivery Day Year
Records, P	The lew requires that the ste has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions con	HEAG		culting in the u	nderlying	cause give	n in Part I.				o contribute	to the cause of death? Probably 4 @Unknown
al Reco		Completed									24a. Was a autops perform	sy	prior to death	autopsy findings available o completion of cause of es 2 \square No
on of Vital	Phyeic this ce	tlon: To Be	27. Manner of Death 1 Natural 5 Pending	lospital: 1 lnp 28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		28c. Injury Work	r: 4 🖪 Nur	rsing Hon	Check only or ne 5 Residence 128d. Describe he	ence 6		pecify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		f Injury - At h	ome, farm, str fy)					28f. Location (S City or Town		Number or i	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	ner: On the bas and manne	is of examina	.nwedge, death	vestigation	d at the tim on, in my op	a, date and inion, deat	d plana d	and due to the co	aus (s) a late and p	nd manner lace, and d	us stated. ue to the cause(s)
)	Tot With Tot	Σ	29b. Signature and title of certifier				2	9c. License	number			July	ve	Jeo 5
- 24	Sta	ate	30. Name and address of person who co DENNIS H DIE 31. Date filed (Month, Day, Year)	9106 8	THEAD	ES HA	Po	, 5,			o Bon			21217

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1 Day Month 20185 02:38F Joseph Howard Longo /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical (4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 10XM 2□ F 216-24-9104 Director May 28 1930 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County r then "netural", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Cockeysville 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10125 Charington Rd. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 n/a Police Officer Law Enforcement permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Longo Beulah Rathell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Longo/wife 10125 Charington Rd., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/22/05 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)
21. Signature of funeral Single Lights

Lowell M. Lem Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. $COLON \quad CANCER \text{,} \quad DIABETES$ 23e. Did tobacco use contribute to the cause of death? Be Completed by After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 2 No 24a. Was an autopsy performed? 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2000 Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes Hospital: Medical Certification; To Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. after death.
Director: # 1 TYes 2 TNo 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ja mo 07/20/05 D58656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 OSLER DRIVE TOWSON, MARYLAND 21204
32 Registrar's Signature SABA M.D. 7601 31. Date filed (Month, Day, Year) JUL 26 2005 State Registrar

x 68760,	
, P.O. Box	
Records,	
of Vital	
isior	

		For			t in Black I Iryland / Dep	partment of H	lealth and N	Mental Hy	_	ible.	
	•	State Registrar			Ce	ertificate of	Death		Reg. No	0.5	21 2
je sa		1. Decedent's Name	e (First, Middle, L	ast)				2. Date of De	ath CU	0 3 -	8. Time of
icia: dica		Gwendoly	n Grigg	sby Lamont				July 24	1, ^{Day}	Year	6:06
nine	_	-	-	ive street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
*	igit.	Gilchris				Towson			Balti	more	
al		5. Social Security N		4 C 44 2 X C	(In yrs. last birthda)	y) If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)		place (State or ntry)
or		219-28-3 Usual Residence of	094		77 Yrs.			May 16,	, 1928	Tenn	essee
și.	Ì	10a. State	10b. County		10c. City, Town or	Location				1	I Od. Inside Cit
	ğ	Maryland	_		Baltimor	re					1 📉 Yes
	Directo	10e. Street and Nur	mber		Dartimor	10f. Zip Code			10g. Citizen of	What Cour	ntry?
-	0	3703 Bel	le Avenu	e			21215		United	State	es
	by Funeral		ied 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 2	ever in U.S. 13	B. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🕅 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Rad Blad Afr Specifi	ce - Americ ck, White, itcan-	
		3 🕅 Widowed		Year or Dates:	1.40- 0						
	Completed	(Spec	15. Decedent's E cify only highest g	ducation rade completed)	(Giv	cedent's Usual Occup ve kind of work done DO NOT use retire	during most of work	ing	16b Kind of B Baltimo	re Ci	dustry Lty
	E C	Elementary/Seco	ondary (0-12)	College (1-4or 5 6 +	+)	ol Teache	,		School		-
		17. Father's Name	(First, Middle, Las		Бене	or reache	18. Mother's Nam	e (First, Middle,	Maiden Suman	71e)	
C	To Be	Benjamin					Daisy		lson	,	
F	ř	19a. Informant's Na			19b. Mai	iling Address (Street				State Zin	Code)
		Alonzo D	•			Huntingdo					
1	4	20a. Method of Disp		, 51. (501	20b. Place of Disc	position (Name of		Date	20c. Location -		
			☐ Cremation 3 i 5 ☐ Other (Spec	Removal from State	Woodlawn	ematory or other place Cemetery	July	29, 200	5 Wood	11awn	, Mary
	Ī	21. Signature of Fu			L	22. Name and Addre					-
) Je	Sol) Kallac	MO0333	22. Name and Addre	ty Road	Ing Byer	rs Funer	cal D	irector
		23a. Part1 Enter ti	he disease, or cor	nplications that caused	the death. Do not e-					MD Z	Approximate Interval Betw
		shock/or hea		y one cause on each lin							Onset and D
1		disease or condition resulting in death)	on .	a	consequence of):	cance	٧				month
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13	×	cause. Enter Unde Cause (Disease or that initiated events	injury							1	
	ш	Cause (Disease or that initiated events resulting in death) I		C. Due to (or as a	consequence of):						
		that initiated events		CDue to (or as a	consequence of);						-
1	edicai	that initiated events resulting in death) I			consequence of):						
1	edicai	that initiated events resulting in death) if	Last	d23c. If yes, outcome of	of pregnancy				23d. Da	te of delive	ary
	edicai	that initiated events resulting in death) I	t pregnant months?	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at	of pregnancy 2 Fetal death 3	∃⊟Ectopic pregnanc; □ Other (specify)	,			ite of delive	ery Day Yo
1	edicai	that initiated events resulting in death) (IF FEMALE: 23b. Was deceden in the past 12	t pregnant months?	d. 23c. If yes, outcome of 1□Live birth	of pregnancy 2 Fetal death 3		,				,
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has Ohnseleden Wheelers	by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Unknown	t pregnant months?	d. 23c. If yes, outcome of the birth depregnant at 9 Unknown	of pregnancy 2 Fetal death 3 time of death 5	i ☐ Other (specify)		23e. Did to	obacco use cont	onth tribute to th	Ďay Y
har Ohmelelen /the dise	by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Unknown	t pregnant months?	d. 23c. If yes, outcome of the birth depregnant at 9 Unknown	of pregnancy 2 Fetal death 3 time of death 5	i ☐ Other (specify)		1 □ \ 24a. Was	obacco use cont	tribute to th	Day You not cause of depaths 4 Ur
har Other Soloton Man Alexander	by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Unknown	t pregnant months?	d. 23c. If yes, outcome of the birth depregnant at 9 Unknown	of pregnancy 2 Fetal death 3 time of death 5	i ☐ Other (specify)		24a. Was	obacco use cont Yes 2 500 an 24b.	tribute to the	Day You not cause of de cause of the
October 1 has Observed and Manual and	e Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 5 9 Unknown Part II. Other signif	t pregnant months? SNo	d. 23c. If yes, outcome of the birth depregnant at 9 Unknown	of pregnancy 2 Fetal death 3 time of death 5	i ☐ Other (specify)		24a. Was autor perfo	obacco use control of the control of	tribute to the	Day You not cause of depaths 4 Ur
Conference of the Control of the Con	o Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 5 9 Unknown Part II. Other signif	t pregnant months?	d. 23c. If yes, outcome of the birth depregnant at 9 Unknown	of pregnancy 2 Fetal death 3 time of death 5	i ☐ Other (specify)underlying cause giv	en in Part I. 26. Place of Deat	24a. Was autop perfo	obacco use control obacco use co	tribute to the autoprior to cordeath?	Day You not cause of de lably 4 Uropsy findings a mpletion of call 2 No
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To Do Commission of the Obertal Manual	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown Part II. Other signif	t pregnant months?	d. 23c. If yes, outcome of the little birth difference of the	of pregnancy 2 Fetal death 3 time of death 5 It not resulting in the	ent 3 DOA Other (specify)	en in Part I. 26. Place of Deat	24a. Was autoperformed to the competition of the co	obacco use cont Yes 2 500 an 24b. 1 ssy 275 No	onth all Prob Were autoprior to cordeath? The Yes The Control Problem of the Control Pr	Day You not cause of de lably 4 Uropsy findings a mpletion of call 2 No
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To Do Commission has Observed also described	o Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceden In the past 12 1 Yes 25 9 Unknown Part II. Other signif	t pregnant months? SNo ficant conditions red to medical No h 5 Pending investigatic 6 Could not	23c. If yes, outcome of the line of the li	of pregnancy 2 Fetal death 3 time of death 5 It not resulting in the Int 2 ER/Outpating Year) 28b. Time Injury Year) 28b. Time	ent 3 DOA Oth of 28c. Injur Wor M 1	en in Part I. 26. Place of Deat er: 4 □ Nursing Ho y at k?	24a. Was autop perfo 1 Yes h Check only come 5 Reside 28d. Describe h	obacco use cont Yes 2 500 an 24b. ssy rmed? 2500 dence 6 50th now injury occurr	onth inbute to the strict of	Day You he cause of de pably 4 Dur psy findings ampletion of car 2 No
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Craig Lambert 05-03584 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ارد	04		For State Registrar	State of Ma	7	epartment of Certificate of			iene _{99. No.} 2005	21.307
			Decedent's Name (First, Middle, Last)		- Inoate of	Douin	2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Craig Stua	rt	Lambei	ct		Month May	24 2005	1720 M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Dea	ath	4c. County of Dea	
			514 South Smallwo		e (In yrs. last birthe	Balti		S 9 Data of Birth	Baltimor	
	Funeral Director				40 Yr	Months Day				thplace (State or Foreign ountry) ryland
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e-fsh	ctor	Maryland N/A		Baltimo	ore				1 ☑ Yes 2 ☐ No
	vith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	eath v	erai	2227 Ashton St.	12. Was Decedent	Ever in II S	13 Was Decadent of	21223	(Specify Voc or No.	USA 14. Race - Am	oriogo Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "netural", or iteme 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 H N 		erto Rican, etc.)	Black, Whi	te, etc.
Baltimore, Maryland 21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. D	ecedent's Usual Occ	upation		16b. Kind of Business	/Industry
215	thin 7 e.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5		Give kind of work don ife. DO NOT use retii	e during most of w red)	rorking		
121	filed wi Hygien kher th		12 17. Father's Name (First, Middle, Last)		Mac	hine Oper			Machine S	hop
anc	d be fi	Be c	Albert	٨	Lambei	. +		ame (First, Middle, M	Maiden Sumame)	Emaos
ary	should be filed and Mental Hygi is marked other aumatic event, ii	ို	19a. Informant's Name/Relationship (T	A。 rpe, Print)			Aud		, City or Town, State,	Ensey Zip Code)
Ĭ,	and 2 alth a 27 is er trai		Michael Lambert (Brother)	222	27 Ashton	St., Bal	timore, M	D. 21223	
ore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of D	Disposition (Name of crematory or other pa	lace)	Date	20c. Location - City o	Town, State
ţ	ment tant:	18	`4 □Donation 5 □ Other (Specify,		Loudon I	Park Cemet	ery 5/	30/05 I	Baltimore,	Maryland
Bal	permit Depar Impor any in		21. Signature Funeral Service Licens	ee •••					k Funeral	
			23a. Part. Enter the disease, or comp shock, or heart failure. List only of	ications hat caused	the death. Do no				re, MD 212	Approximate
	Pnysician		Immediate Cause (Final	ne cause on with li	ne.	+ Mari	John	Load		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence of		000	Tarel	_	
	Examiner	L	Sequentially list conditions,	b						
140	led nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
Ž	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	;		<u> </u>		
8760,8	ate be only sicial the buri	dicail		d						
θ	the death certificate y the attending phys iched for use as the		IF FEMALE:							
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnan	ісу		23d. Date of de Month	livery Day Year
o.	at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	5 Other (specify)				
Δ.	s that ned by e deta	by Ph	Part II. Other significant conditions co	ntributing to death b	out not resulting in t	he underlying cause o	given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ords	w requires been sign should be							1 □ Y€	es 20XNo 3∏P	robably 4 Unknown
Records,	B 8 6	ompleted						24a. Was ar	v prior to	utopsy findings available completion of cause of
E B		Соп						perform	ned? death? 2 ☐ No 12 Ye	·
Vital	Phyeician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only on		
of		To I	XXYes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Monn, Da		atient 30 DOA	4 🔲 Nursing	Home 5 Reside	once 6 X Other (Special of the second of the	ecity) Scene
ion	Attending Ir death. ector: After by the funer	atior	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Monta, Da	y Year) Ini		ork? □Yes 2X1No	Suly	est sho	+
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farn c. (Specily)	n, street, factory, offic	Э	28f. Location (St.	reet and Number or F	tural Route Number,
	ital or irs efte rel Dire			- Canaling, or	YAR	D		514 5,	mallace	rol ST.
	To the Hospital or within 24 hours effe To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one) 2 Medical Exam	ner: On the basis o	f examination and/	death occurred at the or investigation, in my	time, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	and manner st	a.Gu,	29c. Lice	nse number	25	9d. Date signed (Mon	th, Day, Year)
	0) () (who i	\mathcal{M}		OC	ME		May, 25,	2005
	V		30. Name and odress of person who c	ompleted cause of c	leath (Item 23a) (T	ype, Print)11 Po	nn Stree	t Baltimo	ore, Maryla	
-	, ,		31. Date filed (Month, Day, Year)	- FEIN	Ψ)				Les TRILYLO	21201
	Sta Registi		IIII 2.5		and the	Sperke				

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Den	artment of Health and Me	•	
				rtificate of Death		2005 24388
		150	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
196	Physicia /Medic		Josephine Lohmeyer		Month July	24 2005 7:00 A.M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
*1		2007	9774 Longview Drive	Ellicott City		Howard
ľ	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	- Director		215-24-0326 To Mark 2017 To Mar	l M	lay 26,1	929 Maryland
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e-fsl	ctor	Maryland Howard Ellicot	t City		1 ☐ Yes 2 ☑ No
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	s 238	rai	9774 Longview Drive	21042		U.S.A.
	ter de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
336	urs af	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	72 ho	Completed by Funeral Director	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry
2	ithln 7	nple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)		
	led w lygier her th	S		emaker		Own Home
and	tal Hedol	Be	17. Father's Name (First, Middle, Last) Paul Guercio	18. Mother's Name (
Maryland	hould d Mei mark metic	^L		Josephin ng Address (Street and Number or Rural R		
Z	od 2 s Ith an 27 is					
ē,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)		City, Maryland 21042 c. Location - City or Town, State
Ë	Page nent o nt: If		Labourial 2 Cremation 3 Hemoval from State	Cemetery 7-28-	2005 Ba	altimore, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23c or 28e-f show eny injury or other treumetic event, If a Modical Executive resulted at once.			2 Name and Address of Facility Itzke Funeral Home		
m	89 2 2 3		Comas la were "	630 Edmondson Ave.	Catonsvi	ille, Maryland 21228
ľ			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arrest	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Care, No. A	OF THE LU	NE	Onset and Death GOSS.
g	/Medical [·] Examiner		Due to (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
/	uted d ansit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispase of Lifery that initiated events			
o	te be executed ysicien and ie burial-transit	cai Examiner	resulting in death) Last Due to (or as a consequence of):			
68760,			d			
<u> </u>	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE:			
Box	attend for us	ian	If the past 12 mgmms:	Ectopic pregnancy		23d. Date of delivery Month Day Year
<u>Р</u> О	the d	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		
	s that ned b deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Records,	w require been sig should b		CHRONE OBSTRUCTIVE ALL	MEJARY DISEASE	1 Yes	2 No 3 Probably 4 Unknown
ဝ၁	aw requast been 2 shouk	Completed			24a. Was an	24b. Were autopsy findings available
œ —	The ate har page	Com			autopsy performed 1 Yes 2	prior to completion of cause of death?
/ita	clen: ertific	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
Division of Vital	Phyeiclen: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	2	1			
O	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	f 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	d. Describe how	injury occurred
/IS	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be		. Location (Stree	at and Number or Rural Route Number.
ā	s afte	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place, and	due to the caus	e(s) and manner as stated.
	the H hin 24 the F nplete	Medical	one) and manner stated.			
,	To with con	<	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	7			0002584		ULY 25, 2005
	30		30. Name and address of person who completed cause of death (Item 23a) (Type, CHM'STNE'L. COMMETTER	20		21229
	Sta	te	31. Date filed (Month, Day, Year) Registrar's Signature	13767177	sac jo	" CIECI
	Registr		JUL 2 6 2005 Keeper & April			

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician Month /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death 5505 LAURELTON AVENUE BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 6-32-53 88 Yrs Director SEPT. 18,1916 UKRAINE Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MD. or 28a-f BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5505 LAURELTON AVENUE Nerna 23a Funeral 21214 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Š Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry si Hyglene. Elementery/Secondary (0-12) Cotlege (1-4or 5+) MACHINE OPERATOR MANUFACTURING permit. Peges 1 end 2 should be file Department of Heelin and Marring Inportant: If item 27. Be 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN LYCHOLAT UNKNOWN 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ond is ont of Heelth er, opportant: if item 27 is region or other. STEVEN LYCHOLAT/SON 5505 LAURELTON AVENUE BALTIMORE MD. 21214 20b. Ptece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAEL'S UKRAINIAN 7/28/05 BALTIMORE, MD. 21. Signeture of Funeral Service Licenses ²²LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart faiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician tmmediate Cause (Finat diseese or condition resulting in death) Medica Examiner Due to (or es a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 24 Unknown 1 Yes 2 No þ cete has been sig r, page 2 should b Completed 24a. Wes en autopsy performed? 24b. Were autopsy findings evaitable prior to completion of cause of deeth? certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only prie) Other: 4 Nursing Home & Residence 6 Other (Specify) Hospitel: Certification: To 1 ☐ Yes 30 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Dete of tnjury (Month, Dey Year) 27. Menmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending within 24 hours efter deeth.

To the Funeral Director: All completely filled in by the fu neral Director: A filled in by the fr investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who ampleted cause of deeth (Item 23a) (Type, Print) lows NO 21 204

Registrar

State

31. Date filed (Month, Day, Year)

2 6 2005

32. Registrer's Signeture

			1 - For State Registrar	State of I	Maryland		artmen rtificate			and M	F	Reg. No	05	21390
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Dea Month	Day	Year	-3. Time of Pealtr
	/Media	cal	4a. Facility Name (If not institution	Marea M			4h Cihr	Town or	Location of	of Dooth	July		005 nty of Death	<u> 7:55 A™</u>
	Examir	ıer	Ridgeway Manor						ville				Balti	
	Funeral	57.	5. Social Security Number 215-07-1004		Age (In yrs. k	ast birthday) Yrs.	If Under Months		If Under Hours		8. Date of Birt (Month, Da)	h y, Year)	9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		71	115.					FEB 4,	1914	Mar	ryland
	72 hours after death with the Maryland natural', or items 23e or 28a-f ehow bisal Exactings was be multified at	ctor	Maryland Bal	timore	10c. City	, Town or Lo	Cato	nsvi	11e					10d. Inside City Limits 1 ☐ Yes 2X No
	with the	Director	10e. Street and Number 5743 Edmond:	son Avenue			10f. Zip		1228			10g. Citizen o	of What Cou US	
	ms 23	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	- 14. F	ace - Amer	rican Indian,
036	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Heelth and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28a-f ehow or other treumatic event, the Madical Examiner is set to inflied at	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Force ied 1 Tyes 2 If Yes, Give Year or Date			1 Yes, spec		n, Mexicar Specify:		Hican, etc.)	Spe	slack, White	_{n,etc.} √hite
21215-0036	n 72 ho "natur	Completed	15. Decedent (Specify only highes	t grade completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during mos	t of worki	ng	16b. Kind of	Business/I	ndustry
212	d within giene.	Comp	Elementary/Secondary (0-12)	College (1-4	or 5+)	Но	memak	er					Own I	· Iome
Maryland	S should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ite M.	To Be (17. Father's Name (First, Middle, Clarence Sylv		ker				18. Mothe		(First, Middle, Marea			
Mary	12 shound Nand Nand Nand Nand Nand Nand Nand Na		19a. Informant's Name/Relations	hip (Type, Print)							I Route Numbe			ip Code)
	Heelth tem 27 other tr		John Moore/son 20a. Method of Disposition			L035 lace of Dispo	Dais	ne of			ine, M	20c. Locatio		Town, State
Baltimore,	Pages nent of ent: If i		1 🖄 Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S			John				//27/	05	Ellico	ott Ci	ty, MD
Balt	permil. Pages Department of H Importent: If ite any injury or of		21. Signature of Funeral Service	McDonald	l						me, P.A Cator		o. MD	21228
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cau only one cause on each	n line.		ter the mod	e of dyin		cardiac c	or respiratory ar			Approximate Interval Between Onset and Death
	/Medical Examiner	Ļ	resulting in death) Sequentially list conditions,	Due to (or b. Cere	as a consequ	ience of):	thee							
	cuted id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dial	setes	m	eex	w						10 years
8760,	certificate be executed uding physician and use as the burial-transit	icai Ex	resulting in death) Last	d. Uriv	as a consequ	ience of):	psig	\$						13days
O. Box 6	certific nding p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 ∏ Fetal ntat time of de	death 3[□Ectopic pr □ Other (sp						Date of deliment	very Day Year
Q.	98	b	Part II. Other significant condition	ons contributing to deat	th but not resu	ulting in the u	inderlying c	ause give	en in Part I		23e. Did to	-		the cause of death?
Records,	The kite his	Completed									24a. Was autor perfo	an 24 osy rmed 2 No	death?	topsy findings available completion of cause of
Vital	Physiclen: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital				Oth	or /		(Check only o			
of	Phys this ral dii	on: To	1 Yes 2 No 27. Manger of Death 1 Natural 5 Pendin	28a. Date of (Month,		ER/Outpatie 28b. Time o Injury	of 2	28c. Injun Worl	at k?		me 5 Resident			ify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	f Injury - At ho , etc. <i>(Specif</i> y	ome, farm, st	M reet, factory		Yes 2□		28f. Location (S City or Tox		mber or Ru	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the be Examiner: On the bas and manne	is of examinat	wledge, deat tion and/or in	th occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifie	20	h	11)	290		e number	~		29d. Date sig		
•	11		Many	Jums		· .		U	195	28		Ju1	y 25	, 2005
1	0		30. Name and address of person Elen E. J.	who completed cause ohuse.	of death (Item	716 M	aiden	cho	ice l	-a 5	Stero	5, B	alt.	md, 21228
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Aeg	gistrar's Signa	S. A	nach							

-04958		Please	State of Mai			c. Ensure All Health and M	•	3	
1		1- For State Unpend Item Registrar	23a, pt.II,	27,28a-£a	PATICER S	345e Zm29-0	F .	ag. No. 2005	24391
Physic /Med		1. Decedent's Name (First, Middle, Las Margare	sı) et Mattia				2. Date of Deat Month July	21 2005	3. Time of Death
Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of Deat	h
		Anne Arundel Med	dical Cente	r	Annapo			Anne Aru	ındel
Funeral Director	_	579-50-4805	7. Age	(In yrs. last birthday) 67 Yrs.	Months Days		8. Date of Birth (Month, Day, DEC 20	Year) Co	hplace (State or Foreign untry) 110
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
itied within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "naturel", or itema 23a or 28a-f show ant, the Mudical Exaction court to notified at	Ď	Maryland Anne Ar	mundo1		Dea	1.			1 ☐ Yes 2 X No
r 28a-f	Director	10e. Street and Number	under		10f. Zip Code	ie	1	0g. Citizen of What Co	untry?
ath with 23a or		6000 Parker Dr	ive		2075	51		USA	
ter deat Itema	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
or the			1 Yes 2 XNo	•	1 ☐ Yes 2 🏋 No		riicari, etc.)	Black, White	
72 hours naturel',	A P		Year or Dates:						√hite
n 72	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	e during most of work	ing	16b. Kind of Business/	Industry
withi iene. than	l mo	Elementary/Secondary (0-12)	College (1-4or 5+)		/Appraiser		Antiques	
Hyg other	BeC			Quil	t Dealer,	18. Mother's Name			
should be nd Mental marked (ToB	Stephen Sziarto				Marga	aret Nag	У	
permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturany or other treumstic event, the Medical and sone."	ļ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	et and Number or Run	al Route Number	City or Town, State, 2	Zip Code)
and and a salth m 27 i		Donald L. Mattia	/Husband) Parker		ale. MD	20751	
of He		20a. Method of Disposition 1 Durial 2 Coremation 3 D	Removel from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pl	ace)	Date	20c. Location - City or	Town, State
Pages ment of ant: if it		4 □Donation 5 □ Other (Specif		Metro Cre	ematory,	Inc. 7/2	5/05	Baltimore.	MD
permit Depart Import any in		21. Signature of Funeral Service Licer	2 hl	C.	2. Name and Addr	ress of Facility Society	of MD Tr	nc	
70760			orchik	2	99 Frede	rick Road	Baltimoi	nc. ce, MD 2122	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line	he death. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician Medical		Immediate Cause (Final disease or condition resulting in death)			larcotic	Intoxicat	ion and	Hypertherm	
Examiner			Due to (or as a	consequence of):					
	e l	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):				-	
be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
ate be nysicii ne bu	cal		_ d.						
leath certificate I attending physi	Physician/Medic	IF FEMALE:						1	
w requires that the death cer been signed by the attendin should be detached for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		⊒Ectopic pregnan	су		23d. Date of dei Month	ivery Day Year
the a	Sic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant at ti 9□Unknown	me ol death 5[Other (specify)			MOUNT	Day 16a
that the sed by detac			contributing to death but	not resulting in the u	inderlying cause o	even in Part I	23e Did toh	pacco use contribute to	the cause of death?
signe d be	Q p				_			es 2 No 3 Pr	1/
v req	Completed		F						
has ge 2	dm						24a. Was a autops perform	y prior to a	stopsy findings available completion of cause of
in: T	ပိ						1 ☐ Yes 2	No 1 □ Yes	2 No
rsicie s cert	0 8	examiner?	Hospital: 1 Inpatien	t 2∕CX ER/Outpatie	nt 3□ DOA O	26. Place of Deat		·	-61
erathis	11-	144	28a. Date of Injury	28h Time o	III JU DON	4 🗆 Nuising H		once 6 □Other (Special of the following occurred)	unk
ath. F.: Afte	ertification:	1 □Natural 5 □ Pending 2 □ Accident investigation	Fourfd ^{th, Day} 7-14-05	Year) Injury		ork? ⊒Yes 2 1 √∑No			dik
Attended of the py the py the	III.	3 Suicide 6 Could not b	e 28e. Place of Injur	y - At home, larm, st	reet, factory, office		281. Location (St.	reet and Number or Ru	ıral Route Number,
ital or rs aft	Ce			residenc	e]	Deale, M	^{n. State)} 6000 Pa D	arker Dr.,
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ▼ Medical Exar	nysician: To the best of minar: On the basis of e and manner state	examination and/or in	th occurred at the overtigation, in my	time, date and place.	and due to the ca	use(s) and manner as	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	1	4	_	nse number	2	9d. Date signed (Mont	h, Dey, Year)
1		/ Caral	Halla	n md		CME		July, 23,	2005
Own)	1	30. Name and address of person who	completed cause of deal	ath (Item 23a) (Type,	Print)	α:			
) (NO /	1/				111 Pe	enn Street	Baltim	ore, Maryl	and 21201
NEW A CO.	tate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature					

State Registrar

			For State Registrar	State of	Maryland /		artmen <i>tificati</i>			and M		giene ()	05	24392
	Physici /Medic		1. Decedent's Name (First, Middle, Last Suzanne E. M								2. Date of Dea Month July		2005	3. Time of Death 8:19 A M
	Examir		4a. Facility Name (If not institution, give 408 Haverhill Roa	d	er)		Jop	pato					ity of Death	d
	Funeral Director		5. Social Security Number 6. Se 059-44-2836	х]м 2 Д F	Age (In yrs. last I	Vrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day JUL 17	, 1951	9. Births Coul New	place (State or Foreign htry) York
	Maryland e-f show	tor	10a. State 10b. County Maryland Harfor	d	10c. City, To	own or Lo		ewoc	od				1	0d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28	ral Direc	10e. Street and Number 1949 Brookside Dr	ive			10f. Zip	Code	21040)		10g. Citizen o	f What Coul	ntry?
036	ours after dea ai', or items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decede Armed Force 1 ☐ Yes 2. If Yes, Give Year or Date	ss? <u>V</u> No		Vas Deced f Yes, spec I □ Yes		spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bi	ace - Americ lack, White, sify:	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f show eumatic event, the Medical Eventual counties and the counties.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4	or 5+)	(Give life. L	lent's Usua kind of woi DO NOT us etary	rk done d e retired	lurina most	t of worki	ng	16b. Kind of	Business/In	·
/land	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Robert N. Laza	r							(First, Middle, Havas			
e, Mar	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (7) Barbara Porter/si	pe, Print) bling		408]	Haver	hill	Roac	i Jo	ppa, MI	21085	·	
timore	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic: 0009.		20a. Method of Disposition 1 Burial 2 Termation 3 F 4 Donation 5 Other (Specify)		20b. Place ceme Metr	o Cr	natory or or emato	ry,	Inc.	7/26			imore	
Ba	permit. Departr Importe any inju		21. Signature of Furgeral Service Licens Thomas Greg	ory	sed the deeth. D	\perp 2	99 Fr	eder	ick F	Road	of Maryl Baltin	ore. M	ne. ID 212	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)	m	as a consequence	atic		iv.		_	COV	est,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequenc	e of):								
8760,	cate be executed physician and the burial-transit	dicai	resulting in death) Last	Due to (or	as a consequenc	e of):								
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 movems? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal dea t at time of death		Ectopic pre						ate of delive	ery Day Year
ords, P	w requires that been signed b should be det	by	Part II. Other significant conditions co.	ntributing to deat	h but not resulting	g in the ur	nderlying ca	ause give	in in Part I.		23e. Did to			ne cause of death? ably 4 □Unknown
Vital Records,		Completed					-				24a. Was a autops perform	med?	prior to con death?	psy findings available inpletion of cause of
Division of Vita	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of I (Month,	Day Year)	. Time of Injury	21 M	Bc. Injury Work 1 D Y	^{n:} 4□ Nui at	rsing Hon	(Check only or ne 5 ☐ Reside 28d. Describe he	ence 6X O		Sister's Necidence
DİVİ	Hospitel or Attence 44 hours after death Funerei Director: tely filled in by the	I Certifi	4 Homicide determined	building,	Injury - At home, etc. (Specify)						City or Town	n, State)		I Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I.	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	ner: On the basi	s of examination a stated.	and/or inv	estigation,	in my op License	inion, deat	h occurre	ed at the time, d	ate and place	ed (Month,	the cause(s) Day, Year)
		/	30. Name and address of person who come of the company of the comp	empleted cause of	M. D	ı) (Tvpa. F	Print)	D 4	153	90		July	25,	2005
/	Sta	te	31. Date filed (Month, Day, Year)	22. Reg	strar's Signature			od 1	Coal	人#	-200,	Beli	Hir,	MD21014
4	Registr	ar	JUL 2 6 2005	Status	J. J.	PON								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 0 5

			For State Registrar	State of Maryland / Dep	eartment of Health and Me ertificate of Death	ental Hygien Rag. N		24393
36	Physici		Decedent's Name (First, Middle, Last) ARIF.	ELIZABETH	MCCIAN	2. Date of Death	Day Year 2005	3. Time of Death 3:35 P _M
).	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Toyn, or Location of Death	V	4c. County of Death	
	Funeral		5. Social Security Number 6. Sec	111 011/2	10	8. Date of Birth (Month, Day, Yea APRIL 29	9. Birth	place (State or Foreign
	Director	8	Usual Residence of Decedent	01 113.		APRIL 29,1	1921 NORT	H CAROLINA
	Marylar I ehow	tor	10a. State 10b. County	10c. City, Town or L	IMORE			10d. Inside City Limits 1 Yes 2 No
	death with the Maryland me 23a or 28a-f ehow	Funeral Director	10e. Street and Number	An	10f. Zip Code 21206	10g. C	Citizen of What Cou	intry?
	teme 23	ınerai	3405 WHITE	Armed Forces?	. Was Decedent of Hispanic Origin? (Spelf Yes, specify Caban, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White,	
960	hours after ural', or ite		1 ☐ Never Married 2 ☐ Married 3 M Widowed 4 ☐ Divorced	1 ☐ Yes 2 V No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: 6	LACK
21215-0036	n natu	Completed by	15. Decedent's Edu (Specify only highest grad	e completed) (Giv.	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	16b.	Kind of Business/In	ndustry
	filed within Hygiene. Ither then "	Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	MANAGER	BM (First, Middle, Maide	TIMORE CH	Hy SCHOOLS
Maryland	2 should be tand Mental I is marked or aumatic eve	To Be	PERCY My	AH		ANDUA	ED WAR	RDS
	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hyglene. Item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow other traumatic event, the Modical Examiliar must be mailified at		19a. Informant's Name/Řelationship (Ťy	pe, Print) 19b. Mail ANGHTER 3100	ling Address (Street and Number or Rural		or Town, State, Zij	Ode)
Baltimore,			20a. Method of Disposition 1 Deurial 2 Cremation 3 P	emoval from State	position (Name of Dematory or other place)	ate 20c.	Location - City or T	own, State
altin	permit. Page Depertment of Importent: If any njury or once		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	MARYLANI	22. Name and Address of Facility A	0.05 L	AVKEL IN	NERALHOME
m ====================================	Dep Imp		23a. Part1. Enter the disease, or compl	cations that caused the death. Do not ex	905 YORK ROAD D	DATIMORE		ND 21212 Approximate
d	Physician		Immediate Cause (Final disease or condition	cations that caused the death. Do not en the cause on each line.	renal disease			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	roien			Here.
	pel ist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a donsequence of):	7 0000			
oʻ	e execution and urial-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760,	lificate be executed g physicien and as the burial-transit	edicai	•	I				
Box	death ceri e attendin id for use	Physician/M	in the past 12 months? 1 Yes 2 No		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
, P.O.	law requires thet the de as been signed by the 2 should be detached		9 ☐ Unknown Part II. Dther significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to t	he cause of death?
ords	requires	eted b	Congetion H	eart failur	seconday 70	1 🗌 Yes	2 Mo 3 □ Prol	bably 4 Unknown
Vital Records,	e las	Completed by	DALU	SLAV MEAST OCCE	₹ <u></u>	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death Other:			7 +
Division of	Attending Physician: or death. ector: After this certific by the funeral director.	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28B. Time Injury	ant 3 DOA 4 Nursing Hom	ne 5 Residence 8d. Describe how inj		वा यह जा
/isio	Attendir death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	M 1 Tes 2 No	8f. Location (Street a	and Number or Rur	al Route Number.
Ö	pitel or ours afte eral Diri		4 Nothicide	building, etc. (Specify)		City or Town, Sta		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one)	initian: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date a	(s) and manner as s ind place, and due to	o the cause(s)
	To To	2	29b. Signature and title of certifier	Ly Rilym	29c. License number		Date signed (Month,	
Sid.		- A	30. Name and address of person who co	mpleted cause of death (II im 23a) (Type	11 -11	St. Ba	Cto. md	2120x
1	Sta	1 T II	31. Date filed (Month, Day, Year)		fork!			
Aug.	Registr	ar	JUL 2 6 2	005	A CONTRACT			

Physician /Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

harlotte

Physician

/Medical

Examiner

Funeral Director

	5. Social Security Number 220-14-3902	6. Sex 1 □ M 2 💢 F	_	in yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bi (Month, Di July 1	av. Year)	926	9. Birthplace (State or Foreign Country) Maryland
5	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	1	Oc. City, To	wn or Loc	Perry H	'all					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	10e. Street and Number 4304 Silver		ad.			10f. Zip Code	211	28		10g. Citi		nat Country?
and a disciplination	11. Marital Status 1 Never Married 2 Mar. 3 Widowed 4 Divorced	12. Was Dec Armed For ned 1 Tyes If Yes, Gi	edent Evorces? 2 X No	er in U.S.		/as Decedent of I Yes, specify Cub			cify Yes or N lican, etc.)	0-	Black,	- American Indian, White, etc. White
Population	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12th Grade	it's Education st grade completed) College ((Give k life. D	ent's Usual Occupion of work done to NOT use retire	during m	ost of workin	g		ind of Busi Iwn H	iness/Industry
	17. Father's Name (First, Middle, Charles Work								(First, Middle Lebecca			
	19a. Informant's Name/Relations Valentine W. M		lson Jr.		3343	g Address (Stree Level R		Churc	chville	e, MI	21	028
	20a. Method of Disposition 1		State	ceme	tery, crem 100 d		/	7/27/		Balt	timor	e, Maryland
	21. Signature of Funeral Service	سلعلاس	ŭ.			Name and Addr 705 Belo					ral 1	
	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Due to	each line	HJ/	'οχι :e of):	A						Approximate Interval Between Onset and Death
Total Evaluation	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a	VIC- consequence consequence	e of):	Ruciiv	t L	unc-	DISE	\$\$ \$\int \text{\$\frac{1}{2}}\$		
yaiciaining	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown		birth 2 nant at ti	pregnancy Eetal deame of death		Ectopic pregnand Other (specify)	у		-w- =-		23d. Date Mont	of delivery h Day Year
2 2	Part II. Dther significant condition — SEPS		death but	not resulting	g in the un	derlying cause g	ven in Pa	rt I.		tobacco i		oute to the cause of death?
ounbier.	-Cerebro	VASCULA	L	Ac	-108	-			per	s an opsy formed? 2 10	pri de	ere autopsy findings available or to completion of cause of sath? Yes 2 \sum No
5	25. Was case referred to medica						26 Pla	ce of Death	(Check only			1163 2010
	examiner?	Hospital:	Inpatient	2 🗆 🗆	Outpatient	t 3 DOA			ne 5 Res		s □Other	(Specify)
ation, it	27. Manner of Death 1	28a. Date		281	o. Time of Injury	28c. Inju		2	8d. Describe			
Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
edical		ng Physician: To the I Examiner: On the and ma		xamination		estigation, in my	opinion, c	eath occurre		date and	d place, ar	nd due to the cause(s)
Ξ	29b. Signature and title of certific	er - MO				29c. Licer	sa numbe	ار ا		Juli	ite signed	(Month, Day, Year)
	30. Name and address of person DENNIS ++	who completed cau	use of dea	ath (Item 23	a) (Type, l	Print)	S	urte	200	BA	40-	1005 MD 1/237
e r	31. Date filed (Month, Day, Year	^{32.}	1100001101	o orginatora			4810-200		i i i i i			
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Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

		li	1 - For State Registrar	State of M	Marylan	id / Depa <i>Cei</i>	artme rtifica	nt of H ate of L	ealth a D <i>eath</i>	and M		giene Reg. No	00	5	24395
			Decedent's Name (First, Middle, Last)									2. Date of Death Month Day Year			
	Physici /Medio		Estrella S. Miller								July 25, 2005 8:30 A				
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De												
			Franklin Square Hospital					Rosedale				Baltimore			
ŀ	Funeral Director		184-20-7777	x □M 2∏F				If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birt (Month, Da Dec. 28	y, Year)	rear) 9. Birthplace (State or Foreig Country) 1927 Pennsylvania		
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo					1	10d. Inside City Limits				
21215-0036		ō												1 ☐ Yes 2 ☑ No	
	288-	rect	10e, Street and Number 10f, Zip Code									10g. Cit	itry?		
	3a or		9904 Forge Park Rd. 21128									L	U.S.A.		
	ms 2	Funeral Director	11. Marital Status	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other traumatic event, the Medical Evantrier must be notified at any injury or other traumatic.	by Fui	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No 1 □ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:					1 ☐ Yes 2 💢 No Specify:						Specify: White	
ŏ		ted	15. Decedent's Education 16a. Decedent's Usual Occupation								16b. Kind of Business/Industry				
21	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4c	1-4or 5+)			kind of work done during most of workin DO NOT use retired)							
	ed wil	Con	12th Grade					omemaker					Own Home		
Maryland	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "traumatic event, the Me.	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name							
З́а	ould Men Marke	유	James Boyd							eren		embo			
Jar	12 sh n and r is m		19a. Informant's Name/Relationship (T)		nd1		_				Route Numbe	-			
	1 and 1ealth sm 27 ther tr		Joseph A. Miller 20a. Method of Disposition	(husba					PWLR I		Perry				128
3altimore,	Pages nent of h int: if ite ury or of		1 Burial 2 □ Cremation 3 □ F					tory or other place)					20c. Location - City or Town, State		
Ħ	it. Partmer		* 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Furreral Service Licens		IILE						9/2005 Fallston, Maryland				
Ba	permit. Departr Importe any inji		21. Signatural Fundal Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236										es		
	Physician		23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and enterval Between Onset and Death												
1	/Medical		disease or condition resulting in death) Due to (or as a consequence of):												
ш	Examiner		Sequentially list conditions	b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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8760 _f	cian a	E												·	
87	cate physi the b	dical	•	d .											
9 ×	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy									23d. Date of delivery		
Вох	atten atten for u	cian	in the past 12 months?	al death 3 = Ectopic pregnancy						Month			Day Year		
o.	y the	ıysi	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown											
Δ.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									Did tobacco use contribute to the cause of death?			
g	quire; n sig uld bu		24								1 ☐ Yes 2 No 3 ☐ I				ably 4 □Unknown
Records,	s been si	Completed									24a. Was				
æ	The lav	шо									performed? death?			ath?	npletion of cause of
Vital		BeC	25. Was case referred to medical	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)											
₹ <	ding Phys n. After this funeral di	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursin						rsing Hon	Home 5 ☐ Residence 6 ☐ Other (S))
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				28c. Injury at Work?		2	8d. Describe h	ow injur	ury occurred		
Ö		atlo	2 Accident investigation	M 1 Tyes 2 No						No					
Division	i Dift o	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined									nd Number or Rural Route Number, te)			
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C													ated. the cause(s)
	omple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											Day, Year)	
	->-0		DM54478 7								71	26	100		
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pr Michael Ripkin 9000 Frenderic Square Dn Belline MED 2/257												
	1		Pr Michael Pipkin	9000 }	reales	1. Sq	vor	Da	Bell	rice	ne	> 2	-12	.39	2
	Sta		31. Date filed (Month, Day, Yar)	32. Regi	stror's Signa	ature	1								

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DHMH 17 Rev 1/2001

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AMES MASON

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Registra

		ŀ	For State Registrar	State of M	arylar		artmen rtificate					Reg. N6)	105	21.307
}	Physici		Decedent's Name (First, Middle \(\sum \) T A	MYERS							2. Date of D	Day	Year 2005	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution	, give street and number)			4b. City,	Town, or	Location	of Death	(unty of Death	
				SPITAL			RANG						TIMOR	
	Funeral Director		5. Social Security Number 2.4.40.5036 Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 🗷 F	81	last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Ye <i>ar)</i> 1923	9. Birth Cou	place (State or Foreign intry) MD
	72 hours after deeth with the Marylend Insturel', or Items 23s or 28e-f show diest Evertinet-rout be notified at		10a. State 10b. County	1		y, Town or Lo								10d. Inside City Limits
	he Ma 28e-f s	ecto		I A	BAL	TIMORE		-						1 No 2 No
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121	be filed within 72 ho tal Hygiene. d other than "natur event, the Medical		12 TH GRADE 17. Father's Name (First, Middle, I	L YRS.		30400	OL 18	EACH		- d- N	(Fr			СПУ
Maryland		To Be	WILLIAM FREDR	ŕ					GRA() (First, Middle	e, Maiden Su	mame) UNI	
lary	and and le m eum		19a. Informant's Name/Relationsh			1	-			er or Rura	il Route Numl	per, City or To	own, State, Zi	p Code)
	s 1 and if Health Item 27 other tr		RANDOUH MYER 20a, Method of Disposition	3 (HUSBAND))	3120 /		-	UY.), MD	21215	inn Oibean T	Carrier Change
nor	0 0		1 ■ Burial 2 □ Cremation 1 ■ Donation 5 □ Other (Sp		0	emetery, cren BUTUS	natory or of	ther place		07.28			ion - City or T	own, State
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service L		- AK		. Name and	d Addres			ERAL SI	BALTO.	IIID	
<u> </u>	20 E E S		Dangh (515	51 BAU	D. N	ATL P	IKE,	BAUD.	mo 212	229	
	Pnysician /Medical Examiner		23a. Part1. Enforthe disease, or shock, or heart failure. List of the shock of the	aDue to (or as	ne. HEI	MER				s cardiac o		arrest,		Approximate Interval Between Onset and Death
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):								
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8760	ate be nysicia he bur	icai		d										
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	Ectopic pre					23d	. Date of delive Month	ery Day Year
	law requires that the as been signed by the 2 should be detached	by	Part II. Other significant conditio	ns contributing to death b	ut not res	ulting in the ur	nderlying ca	ause give	n in Part	I.				the cause of death? bably 4 🕸 Unknown
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Vita	Physicien: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho		e of Death	(Check only	one)		
o	Phys this ral dii): To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	iry	ER/Outpatien 28b. Time of		A Othe Bc. Injury Work	4 🗆 N		me 5 🗆 Res 28d. Describe			fy)
ion	Attending In death.	ation	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investig		y Year)	Injury	М		(? Yes 2 □]No				
Division	tel or Attendin s after death. el Director: Af ed in by the fur	Certification:	3 Suicide 6 Could n 4 Homicide determi		ury - At ho c. (Specif	ome, farm, str	eet, factory,	, office		3	28f. Location (City or To	(Street and N wn, State)	umber or Rur	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	(Check only 2 Medical E	g Physician: To the best Examiner: On the basis of and manner sta	f examina	wledge, death tion and/or inv	estigation,	in my op	oinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as s ice, and due t	stated. o the cause(s)
)	with Vith To I	Σ	29b. Signature and title of certifier	paragn r	40		29c.	License	number 128	8		29d. Date si	gned (Month	Day, Year) WillS
	6		30 Name and address of person (no completed cause of d	leath (Iten	23a) (Type,		topy	ntal	Car	te,.			
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	locati	,						
	Registr	ar - 3	JUL 2	6 2005 June	give.	No by		was.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) Month JULY 2005 Day **Physician** 11:50P M MMON /Medical 4c. County of Death 4a. Facility Hame (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Cent Baltimore 7. Age (In yrs. last birthday) tf Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** 1 M 2□F 220-36-6562 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28e-f show rthan "naturel", or Items 23a or 28e-1 shovine Medical Examiner must be notified at 1 ☐ Yes 2 KNo Director 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Blac Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4 or 5+) Der Visor Mother's Name (First, Middle, Maiden Middle Pages 1 and 2 should be fill iment of Health and Mental H lent: If item 27 is marked other Be thnie 10 180 M ဥ (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2178 20b. Place of Disposition (Name of gemetery, cremetons Date ation - City or Town, State 20c. 20a. Method of Disposition Burial 2 Cremation moval from State 3 □R ä permit. Page Department of Importent: If any injury or once. · 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA OF THE LUNG YEARS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any location to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician vision of Vital Records, P.O. Box 68760 by Physician/Medical detached for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signing page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown GASTROINTESTINAL BLEEDING Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 1 Tyes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ro the Hospital The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D17695

Registrar

State

ABDALLAH

31. Date filed (Month, Day, Year)

JUL 2 6 2005

DHMH 17 Rev 1/2001

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OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELOU.

M. D.

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 05 State Registrar AMEND ITEM #5 PER FH G845 7 Persyllisate por Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 231 7:30 PM vonne Mason /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution give street and number) Examiner Baltimore Silcrest If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 69 **Funeral** Days Hours Months 1 □ M 2 F Director 213-32-5181 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or items 23a or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-1 show the Jury or other traumatic event, the Modical Examinar inval be notified at 2058. 1 Yes 2 No Baltimore MD Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 USA 3404 tairview 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Black Maryland 21215-0036 Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Sive kind of work done during most of working fire 40 NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle-Last) Be Cator teurson lacon 19b. Mailing Address /Street and Number or Rura Route Number, City or Town, State, Zip Code) a. Informant's Name/Relationship (TIPpe, Print) 3645 Longrehr Windsor Mill, lody A. Mason-Yowell Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see 23a. Part1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Stown MD 2133 Approximate Interval Between Onset and Death Pancreatic Immediate Cause (Final disease or condition resulting in death) (CO) (CO) mouths Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ ≰o 3 Ectopic pregnancy Year Month Dav 5 Other (specify) o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PUD 1 Yes 2 Sto 3 Probably 4 Unknown HAN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Spile Hospital: 1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Division Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051926 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordan Mo Charles St. Sortinors 6565 31. Date filed (Month, Day, Year) JUL 2 6 2005 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2005 /Medical 4c, County of Death 4a Facility Name (If not institution, give street and number) 4b Sity, Town, or Location of Death Examiner edica If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F -56-296i Director Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'netural', or iteme 23a or 28e-f ehow or other traumatic event, the Medical Exeminer must be notified at 1 Yes 2 □ No Director ACTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depurtment of Health and Mental Hygiene, important: if flem 27 is merked other than any injury or other traumatic most. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee E. Baltzmore 51-Dalto. Approximate Interval Between Onset and Death inf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 **Physician** manyl /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit BSIELLI Due to (or as a consequence of) burial-1 Box 68760. attending physician Physiclan/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform meg? 2 No ancomacen Yes 25. Was case referre to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 2 Accident 5 Pending 1 🗌 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ouch M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12al 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item#18, per Inf., FH. 6846, 874/05 TT

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryland		rtificate		ath		Reg. No.		24601
*	Physicia /Medic			ne (First, Middle, Lo Joseph No							2. Date of De Month July	Day 24,		7:00 P ^M
	Examin		Gilcres	t Hospice				Tows	on	tion of Death		Ba	County of Death	
	Funeral Director		5. Social Security I 220–30–6. Usual Residence of	229	Sex 7. Age	e (In yrs. I	69 Yrs.		Days Ho	urs Min.	8. Date of Bir (Month, Da 10/23/3	tn 19, Year) 35	Mary]	lace (State or Foreign try) and
	anyland •how	٦٢	10a. State	10b. County Baltimo	ro		,Town or L						1	0d. Inside City Limits 1 □Yes 2 🛣No
	uth with the Maryland 23a or 28a-f ehow	Funeral Director	10e. Street and Nu			Dare		10f. Zip Ci 2121				10g. Citiz	zen of What Coun	try?
9800	after dea or itame	þ		ried 2 Marned	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			1 □ Yes 2 X	No Spe	c Origin? (Spec xican, Puerto F ecify:	cify Yes or No lican, etc.)		14. Race - Americ Black, White, Specify:White	etc. e
1215-(within 72 hours ane. then "naturei", he wedisel Ex	Completed	(Spe Elementary/Sec 12th	15. Decedent's E cify only highest gr ondary (0-12)	Education rade completed) College (1-4or 5	·+)	(Give	dent's Usual C kind of work DO NOT use	done during retired)	most of workin	g		nd of Business/Ind	·
land 2	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, the Me	To Be Co	17. Father's Name	(First, Middle, Las Novakos		1	LICC	CLICAL		Mother's Name OSE Eli:	(First, Middle, zabeth			
Mary	and 2 shoulealth and M m 27 is marthantian	-		Novakosk			0	ng Address (S Alden (Route Number		r Town, State, Zip	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 a Department of Hes important: If item eny injury or othe		4 Donation			CE	emetery, cre		<i>y</i> Y Address of F	1		Balt edale	cation - City or To Limore, M Funeral MD 2123	Maryland Home
* ·	Physician and /Medical Examiner streams transit streams transi	dicai Examiner	23a. Part1. Enter shock, or he fmmediate Cause disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease o that initiated event resulting in death)	art failure. List only (Final on onditions, mmediate erlying r injury	b. Due to (or as: Due to (or as: Due to (or as:	a consequ	ience of):						He	Approximate Interval Between Onset and Death WMTh
OS @ 19	The law requires that the death certific tle has been signed by the attending p age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf	death 3[□Ectopic preg □ Other (spec				2	23d. Date of delive Month	ry Day Year
	quires that n signed b	þ	Part II. Other sign	ificant conditions	contributing to death bu	ut not resu	ulting in the u	inderlying cau	se given in F	Part I.	23e. Did to	5	se contribute to th	
CO 7 I Reco		Completed									24a. Was autor perfo	osy rmed?	24b. Were autop prior to con death? 1 \(\sum \text{Yes} \)	osy findings available inpletion of cause of 2 No
	ding Phyeician: n. After this certific funeral director.	To Be	25. Was case reference examiner? 1 Yes 2 22. 27. Manner of Dea 1 Natural 2 Accident	₫No	Hospital: 1 Inpatie 28a. Date of fnjur (Month, Day		ER/Outpatie 28b. Time o Injury		Othon	2		dence 6	ther (Specify	140-2010
$LOSKL_{j}$ Division	al or Attendests after death	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined		ury - At ho	me, farm, st	reet, factory, o	office	2	8f. Location (S City or Tox		d Number or Rura	l Route Number,
NOUAKOSKI, Division	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by the	edicai	29a. Certifial (Check only one)	1 Certifying P 2 Medical Exa	hysician. To the best ominer: On the basis of and manner sta	examinat	wiedye, deal ion and/or in	vestigation, in	my opinion	, death occurre	d at the time,	date and	place, and due to	the cause(s)
	To the complete of the transfer of the transfe	Σ	29b. Signature and	d title of certifier Ath	y Alex	n	On	1.0	icense num 25	205		JU	e signed (Month, 1	2005
	30 Sta	te	30. Name and add	Intho	completed cause of a second se	(e C	ture		670	1 N.	Charl	2. St	L. Balt	md 2120x
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** July 25, 2005 10:17 Kirk M. Powers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Brett Ct #328 Essex Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1**X**] M 2□ F Director 159-26-6781 71 3-31-1934 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore <u>Essex</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brett Ct. #328 USA or Iteme 23a 21221 by Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2☐No Specify Specify: 3√Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Consultant Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank B. Powers Marguaritte McDearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itsm 27 is m any injury or other treum 18 Kenilworth Dr, E. Northport, NY Kirk M. Powers, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

3 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-26-05 Baltimore, MD 21. Signature of Funeral Service Licensee Name and Address of Facility
Maryland Mortuary Support * Gregory Fin Enter the disease or con 426 Crain Hwy SW, Glen Burnie, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Final disease or chy dition resulting in death) Enysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Physic P.O. I 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 3 Probably 4 Unknown Completed page 2 should 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: P 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 esidence 6 □Other (Specify) this funeral 27. Manner of Jeath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No nin 24 hours after death. the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20 30. Name and address of person who completed stuse of death (Item 23a) (Type B 2005 Registrars Signature TIVE TE COL State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year William H. Payne 20, 2005 9:39 A /Medical July 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2500 Jefferson Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 06-17-1921 9. Birthplace (State or Foreign Country) Virginia **Funeral** Months 1**X** M 2□F Director 84 Yrs 212-16-4730 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits The Madical Examiner must be notified at Directo 1XXYes 2 □ No NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2500 Jefferson Street 21205 23a USA death Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "netural", or ite 1**X** Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No þ Specify: 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Major Payne Edna Gilliam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela C. Knight/ Granddaughter 2845 Brendan Avenue Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) Garrison Forest Cemetery 07-27-05 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ones Wylie Funeral Home 638 N. Gilmor St.Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC 20 YEARS OBSTRUCTIVE LUNG DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death P.O. I 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 b 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) RES-000 JULY 21ST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JUL 2 6 2005

DHMH 17 Rev 1/200

RAMPATNAM, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE MP 2007

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Registrar
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Tuly 22 2005 11: 20 Pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Ac. County of Death
	Funeral Director		5. Social Security Number 219-01-3541 Online 6. Sex Yors. 7. Age (In yrs. last birthday) 1 M 2 F 87 Yrs. Online 1 Months Days Hours Min. Online 1 Months Days Hours Min. Online 9. Birthplace (State or Foreign Country) Maryland Online 9. Birthplace (State or Foreign Country) Maryland
	death with the Maryland ma 23a or 28a-f show f must be notified at	rector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Columbia 1 ☐ Yes 2 € No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
036	ours after al', or Ita	by Funeral Director	6336 Cedar Lane 21044 United States 11. Marital Status 1 Never Married 2 Married 3 No If Yes 2 No If Yes, Give Year or Dates: WWII 1 Yes 2 No Specify: White
Maryland 21215-0036	n 72 "nai	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chaueffer Newspaper
aryland	s 1 and 2 should be filed withir if Health and Menial Hygiene. Itam 27 is marked other than other treumstic event, the M	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fmma Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, Ma	s 1 and f Health itam 27 othar ti		George Erbe Jr Brother-in-law 239 Wiltshire Lane Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State New Cathodral
Baltir	permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Day id J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, MD 21229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death V—Q V S Due to (or as a consequence of):
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d
P.O. Box 6	The law requires that the death certific site has been signed by the attending p bage 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Vestion Ves
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tal Rec	an: The law tificate has b tor, page 2 sl	e Completed	ANEMIA Congestive Leart failure 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 2 No 25. Was case/referred to medical 26. Place of Death (Check only one)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To B	examiner? 1
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
Ā	1 /		30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Ming Vi 3320 Benson Avenue Daltimore Maryland 21227
	Sta Registr		31. Date filld (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RUTH E. RIVERS 07.22. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CENTIER BALTIMORE GILCHRIST TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day). 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** 1 ☐ M 2 🗷 F 226.20.9170 Director 83 03.10.1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itema 23e or 28e-f ehov The Madical Examinar must be notified at MD NIA 1 Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 5513 NOME AVENUE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College, (1-4or 5+) 11 TH GRADE CUSTODIAN HOSPITAL NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLIFFORD CHAMBERS HAMIE FLOWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY RIVERS 5513 NOME AVE. BALTIMORE (HUSBAND) MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07.28.05 4 ☐ Donation 5 ☐ Other (Specify) MD. NATIONAL LAUREL 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO · NATL PIKE, BALTO · MO 21229 Jangh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yô 4☐Pregnant at time of death Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowled e, death occurred at the time, data and place; and due to the cause(a) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) inplet of cause of death (fter 23a) (Type, Print) N. Chule, St. Ealte. Mid 212de

State
Registrar

31. Date filed (Month, Day, Year)

44

7/22/05

32. Registrar's Signature

		1 - For Stata Registrar	C	partment of Health and lertificate of Death		ne 2005 24407
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Li Emma V. Ridgway 4a. Facility Name (If not institution, gi	7	4b. City, Town, or Location of Deat	July	Day Year 3. Time of Death 4c. County of Death
Funeral Director		215-32-5668	HOSPI+AL Sex	Months Days Hours Min	8. Date of Birth Month, Oay, Ye July 23,	n/a 9. Birthplace (State or Forei 2007 MD 2007 Country)
death with the Maryland ms 23a or 28e-f show rnust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town or Baltimo	re		10d. Inside City Limi
P 5 3	by Funeral	2810 Maudlin Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	10f. Zip Code 21230 3. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerl		USA 14. Race - American Indian, Black, White, etc. Specify: white
n 72 "ne"	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	Outlege (1-401 3+)	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired) Homemaker		Kind of Business/Industry Home
s 1 and 2 should be filed within the Halls and Mental Hygiene. item 27 is marked other than other traumatic event, traum	To Be	17. Father's Name (First, Middle, Las James 19a. Informant's Name/Relationship	Mahon (Type, Print) 19b. Ma	Margare	ral Route Number, Cit	Baker y or Town, State, Zip Code)
Hea Hea tom othe		Emma T. Galeotti 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	20b. Place of Dis	Mahogany Rd., Several Responsition (Name of rematory or other place) ark Cemetery July	Date 20c.	.144 Location - City or Town, State timore City
permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lice	nsee	22. Name and Address of Facility Lo	udon Park Baltimore,	Funeral Home
Pnysician /Medical Examiner		23a. Part 1. Entish the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death 3 W EEK
535	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)	- जिल्ली	23d. Date of delivery Month Day Year
w requires that been signed b should be dete	ted by PI	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
The law ate has b page 2 si	e Completed	25. Was case referred to medical			24a. Was an autopsy performed:	
this la	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 npatient 2 ER/Outpat 28a. Date of Injury 28b. Time	ient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence	
i or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) Injury	/ Work? M 1 □ Yes 2 □ No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
To the Hospitei or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
Within Toth	Ň	29b. Signature and title of certifier	+ Therson m.	29c. License number		Date signed (Month, Day, Year) LLY 18 2005 LLY BALTIMORE
		30 Name and address of horson who	completed cause of death (Item 23a) (Typ	e Print)	^	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item: 8 per F.H.G-845 7727/05 reb State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Ng? 2. Date of Death Month **Physician** /Medical 4c. County of Death (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timor 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign last birthday) If Under 24 Hrs. **Funeral** Days Hours Min. Year) 12-48-201 Usual Residence of Decedent 2 🗆 F Director Yrs. June 17, 1949 Maryland 10d. Inside City Limits 10a. State 10b. County City, Town or Location or 28e-f show treumatic event, it is Medical Exactiner resist by notified at 1 Nes 2 No Director with the Street and Number 10e 10f. Zip Code 10g. Citizen of What Country? 238 Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. and Tiem 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 1€ Specify: þ 3 Widowed 4 Divorced Lac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address Street and Number or Rural Route Numbar permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tree Dle Place of Disposition (Nan 20b. 3 ☐Removal from State Cremation 5 Other (Specify) 21. Signature of Funeral Service I icensee 21229 Approximate Interval Between Onset and Death 23a. Part1. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician 57 /Medical (or as a consequence of): Examiner Sequentially list conditions, I ary, loading to minimum action cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transil 17 2 Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown 9 Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has 2 No 2√Ω No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 EP/Outpatient 3 DOA 5 Hesidence 6 Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by after 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the t 29b. Signature and title of c 29d, Datetsigned (Month, Day, Year) 29c. License number 30. Name and odress of person who completed cause of death (Item 23a) (Type, Pfrint) Cefledor 1000 31. Date filed (Month, Day, Year) Registrar's Signature State 6 Registrar

			For State Registrar	State of Maryla		artment of rtificate o		ind Me	ental Hyg R	iene •g. No20	05	24409
<i>\$</i>	Physici /Medic	911	1. Decedent's Name (First, Middle, Last) Alvin Frank						Date of Deam Month July 13	th Day	Year	3. Time of Death 7:05 p. M
	Examin		4a. Facility Name (If not institution, give s Easton Memorial Ho	spital		4b. City, Town Easto	n	f Death		4c. County Talbo	t Cour	nty
	, Funeral Director		5. Social Security Number 217-62-9443 6. Sex Usual Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Yes Months Day		Min.	B. Date of Birth (Month, Day Jan. 7, 1	Year)	9. Birthpla Countr Mary 1	ce (State or Foreign y) and
	Ba-f chow	Director	10a. State 10b. County Maryland Anne Aruno		city, Town or Lo	5						d. Inside City Limits 1 Yes 2 No
	a within 72 hours after death with the Maryland Jone r than "naturel", or lieme 23a or 28a-f ehow The Medical Evaminer out the motified at	Funeral Dire	104 Claude Street 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	10f. Zip Code 21 Was Decedent of the Yes, specify Communication of the Ye	401	gin? (Spec		United 14. Ra		5. n Indian,
-0036	hours after aturei', or ite	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 💢 N	lo Specify:			Speci	fy: Whi	ite
Maryland 21215-0036	within jiene.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	com <i>pleted)</i> College (1-4or 5+)	(Give	kind of work do DO NOT use ref Ce Offic	ne during mosi ired)			State o	of Mary	
ıryland	should be filed and Mental Hyg marked othe umatic event,	To Be	17. Father's Name (First, Middle, Last) Alvin Frankli 19a. Informant's Name/Relationship (Ty,		19b. Maili	ng Address (Stre	Ger	nevie	(First, Middle, Ve LaCo Route Numbe	ov e y		Code)
	Heelth a tem 27 ic		1vin F. Rehn, Jr. 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	206	. Place of Dispe	Claude Sosition (Name of matory or other)		Anna Da		MD 214 20c. Location		vn, State
Baltimore,	permit. Pages Department of Important: If i any injury or gnce.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	The same of the sa	2	Cremat 2. Name and Ad 47 Duke	dress of Facilit	y Joh	n M. T.	aylor F	uneral	eryland Home,Inc. MD 21401
8760, <	whysicien and burial-transit the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	widen	1		scula	. ^		Approximate Interval Batween Onset and Death
.O. Box 6	The law requires that the death certifics to has been signed by the attending pt page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	⊒Ectopic pregna ⊒ Other (s <i>pecif</i> y					ate of deliver fonth	ry Day Year
ords, P.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the t	underlying cause	given in Part I		23e. Did to	res 2□No	3 🗌 Proba	
tal Record		e Completed	25. Was case referred to medical		-		26. Place	e of Death		rmed? 2 □ No	eat ?	osy findings available inpletion of cause of
ion of Vital	ding Phys	atlon: To B	examiner? 1½ Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. I	Other	ursing Hom	ne 5 Resid	dence 6 🗆 O)
Division	o ii c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, si	treet, lactory, off	сө	2	8f. Location (5 City or Tox	Street and Nun vn, State)	nber or Rurai	Route Number,
	To the Hospital of within 24 hours at To the Funeral Completely filled in	Medical	(Check only 2 Medical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.		nvestigation, in n	ny opinion, dea		d at the time,	date and place	e, and due to	the cause(s)
		2	29b. Signature and title of certifier.	mD			ense number OCME			29d. Date sign		
	∫ 0 Sta		30. Nate filed (Month, Day, Year)	ompleted cause of death (I		111	Penn St	reet	Balti	more,	Maryla	nd 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** AM 24 7:00 2005 Laura Theresa Ruskowski July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 515 Dorchester Road Baltimore Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F 294-12-9453 83 Jan. 4,1922 Director West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla ardment of Health and Mental Hygiens, ardment of Health and Mental Hygiens, or the marked other than "netural", or flems 23a or 28a-1 show fortant: if fear, or other traumatic event, the Medical Exact net mast be multiled at fourth 1 TYPS 2 NO Maryland Baltimore Catonsville Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A.

14. Race - American Indian,
Black, White, etc. 515 Dorchester Road 21228 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Frank Bumbico Catherine Ausilia ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Ruskowski (Daughter) 1002 Sprinfgate Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2005 Balto/Wash Crematory Laurel, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Witzke Funeral Home of Catonsville, 1630 Edmondson Ave. Catonsville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Ventaicular **Physician** Da /Medical Due to (okas a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed dystinidence 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient Other: 4 🗍 Nursing Home 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural After 5 Pending Injury after death.

Diractor: Af
d in by the fu 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059914 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Rollin Baltzmore, GORGE DURST

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 6 2005

32 Registrar's Signature

		For State Registrer	State of M	/laryland	-	artment rtificate					Reg. No	005	244	
Physicia	n	1. Decedent's Name (First, Middle, La George C. Seri								2. Date of De Month uly 2		2005 ^{Year}	4:30	Beath A M
/Medica Examine		4a. Facility Name (If not institution, gire	e street and number	r)		4b. City, 1	Town, or	Location of	of Death		4c.	County of Dear	th	
		429 Church Str	eet			Bro	okl	yn P	ark		Ar	nne Ar	undel	
Funeral Director		214-24-5580	Sex 7. A 1. M 2 □ F	Nge (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bir (Month, Da Apr 17	th ry, Year) 19:	9. Bird Co Mar	hplace (State or puntry) yland	Foreign
Aaryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	rundel	-	rookly		k						10d. Inside City	
vith the P	Director	10e. Street and Number 429 Church Street				10f. Zip					10g. Citiz	zen of What Co	ountry?	
a 23	E .			A Francis III	0 40 1				=in2/Cna	aifu Van av Na		14. Race - Ame	nican Indian	
ar, o	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 K If Yes, Give Year or Dates	§?]No		was Decedi f Yes, speci 1 ☐ Yes 2	ify Cuba	Specify:	n, Puerto R	cify Yes or No Rican, etc.)		Black, White		
thin 72 house.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)	16a. Deced (Give life.	dent's Usual kind of wor DO NOT us	l Occupa k done d e retired	ation furing mos	t of workin	g	16b. Kir	nd of Business	/Industry	
gien gien f, Ibe	0	7	0		Self	emple	oyec					efuse		
od la b	lo Be	17. Father's Name (First, Middle, Las Joseph V. Serio	")							(First, Middle, Selb		Sumame)		
		19a. Informant's Name/Relationship George C. Serio,				-						Town, State, . Land 21		
	Ī	20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. PI	ace of Dispo	sition (Nam	e of			ate		cation - City or		
Pages ment of I ant: If Its ury or o		`4 □Donation 5 □Other (Speci		。 Mea	dowrid	dge Me	em. I	Pk.	7/25/	05	Elkr	idge, 1	Maryland	l
permit. Page: Department o importent: If any injury or once:		21. Squature of Funeral Service Lice	n . O									al Home	•	
Pnysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A ferc	line.	Do not ent	er the mode	of dying	g, such as	cardiac or		rrest,	-	yland 21 Approximate Interval Betw Onset and D 5 y/M	vaen
ate be ohysicia the bur	ncai Exa	Sequentially list conditions if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	is a consequ	ience of):									
at the death certific by the attending plached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic pre Other (spe					2	23d. Date of de Month	- ,	'ear
uires that the n signed by thuild be detached	2	Part II. Other significant conditions	contributing to death	but not resu	ilting in the u	nderlying ca	use give	en in Part I					o the cause of de	
0 - 2	Completed									24a. Was auto perfo		prior to death?	utopsy findings a completion of ca s 2 \(\sigma\) No	ivailable
certificate	a)	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	опе)			
y sign	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpai	jury	ER/Outpatien 28b. Time of Injury		A Othe Bc. Injury Work	4 🗆 NU		ne 5 Aesi 8d. Describe		Other (Specy occurred	ecity)	
tal or Attanding P s after death. al Director: After t ed in by the funera	Jerillican	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of In	njury - At ho etc. (Specify	me, farm, str	M eet, factory,		∕es 2□	-	8f. Location (City or To	Street and wn, State,	d Number or R)	ural Route Numb	DB/,
t hount unar unar		29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exa	hysician: To the bes miner: On the basis and manners	of examinati	wledge, death ion and/or in	n occurred a vestigation,	at the tim	e, date an pinion, dea	d place, a	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
To the b		29b. Signature and title of certifier	es	n		29c.	•	number	14	D	29d. Date	e signed (Mon	th, Day, Year)	
20		30. Name and address of person who	1 1 1	death (Item	23a) (Type,	Print)	ノ -	, ,	<u> </u>	7			<u> </u>	
State	2	31. Date filed (Month, Day, Year)		trar's Signat	yre									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#12, perFH 5845,7/27/05 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Not 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3002 Albert George Sanders, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Year | If Under 24 Hrs. 24. Husp.ta Hanes Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Dec 26, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Days Hours **Funeral** 1**⊠**M 2□F Months 1923 81 Maryland Director 217-16-8411 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Mcdical Examinar must be notified at 1⊠Yes 2□No Baltimore Directo Maryland n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21230 2812 Washington Blvd 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 (1) Yes, Give Year or Dates: 1 Never Married 2 Married White Specify. 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) tool and die makers machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental Iona Clauss Conrad Sanders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 st ment of Health and ant: if item 27 is 1 2812 Washington Blvd, Baltimore, Maryland Doris Sanders - Wife other 20c. Location - City or Town, State altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Loudon Park Cemetery 7/26/2005 Baltimore, Maryland permit. Page Depertment Important: if any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease Unknown Physician -Oronary /Medical ice of) Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-tran Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Winknown Fibrillation, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Regurgitation page 2 s autopsy performed? Yes 214 No has death? 1 ☐ Yes 2 X No this certificate Vital rector 25. Was case referred to medical 26. Place of Death (Check on one Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification; To Ē ō funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide 24 hours at Funeral Cletely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person ...

**Reckar

**Aar) of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue, Baltimore, Maryland 21229 02 degirmenc 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar

DHMH 17 Rev 1/2001

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ODICINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20 Physician ERMELL SHERIFF 2005 /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** MEMORIAL -TIMOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
S. CAROLINA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1□M 2XF Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at BALTIMORE 1 So 2 □ No Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 H. S. A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: BLACK Completed by 3 Widowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mygiene. Elementary/Secondary (0-12) HEALTHCARE College (1-4or 5+) NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Robinson WEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1629 NORTHBOURNE Rd. BATTO, MD. 21239 19a. Informant's Name/Relationship (Type, Print) SON ELOME 20b. Place of Disposition (Name of cometery crematory or other place)
KING PARK CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 125/05 BATIMORE, MD injury or Department of Important: If 4 □ Donation 5 □ Other (Specify) 22. Name and Address of lacility VAUGHN GREENE FUNERAL SCNS 21. Signature of Funeral Service Licensee 4905 YORK ROAD. BALTO, MD. 21212 23a. Part1. Enter the disease, or complications that caused the d-rain. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performi Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2D ER/Outpatient 3□ DOA 1 🗌 Yes Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Hospital or Attending Pl 24 hours after death. Funeral Director: After ti within 24 hours a

Division of Vital Records, P.O. Box 68760,

death with the Maryland

Saltimore,

Registrar

Medical

(Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title

29c. License number

emorial

29d. Date signed (Month, Day, Year)

			For		State of Ma	•	*	artment of H			lental Hy	giene	•	
			1 - State Registrar				Cer	tificate of I	Deat	h		Reg. N	005	24414
ı	Physici	an	Decedent's Name	6	•						Date of De Month	ath Day	y Year	3. Time of Death
	/Medic	cal	E Essilita Namo (16		jive street and number)			4b. City, Town, or	r Loontio	n of Dooth	July	25	∑ ♡ ♂ (County of De	
0	Examin	ier	4a. Facility Name (II	- L	a an tal			/Zas-1	4.	4	- /		3912 W	
	Funeral		5. Social Security Nu	umber 6	. Sex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Year	If Und	er 24 Hrs.	8. Date of Bir	th	9. B	rthplace (State or Foreign
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	and www.		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
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	r 28a	Irec	10e. Street and Num	nber				10f. Zip Code				10g. Cit	izen of What C	country?
	th with	aD	795 N. G	RANTLE	Y STREET			2122	9				USA	
	filed within 72 hours after death with the Maryland Hygiene. other than "netural", or Items 23a or 28a-f show ent, the Medical Examiract mail be indiffed at	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	lispanic (an, Mexic	Origin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Arr Black, Wh	
36	s afte	by Fi	1 ☐ Never Marrie		f 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No	,	1 ☐ Yes 2 🔼 No	Specif	fy:			Specify: 2	IACK
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Maryland	od 2 s lth an 27 ls r		STANLEY	SNEAD	(SON)			CHERRY						1D. 21136
Ē,	f Hea item other		20a. Method of Disp	osition		20b. Place of	Dispo	sition (Name of natory or other place		CONTRACTOR OF THE PARTY.	Date		ocation - City o	
altimore,	Page nent c ant: If ary or		1 Ø Burial 2 L `4 □ Donation		☐Removal from State cify)	DRUID	·			07.30	.05	PIKE	Sville	MD
Salt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show amy injury or other treumatic event, the Medical Examiner man be notified at Once.		21. Signature of Fur	neral Service Lic	ense		VA	Name and Addres	ss of Fac	NE FU	NERAL S	BERV	ICE	
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			shock, or hear	t failure. List on	emplications that caused by one cause on each li	the death. Do a ne.	not ente	er the mode of dyin	ig, such a	as cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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ă	law requires that the death certif as been signed by the attending r 2 should be detached for use a.	Physician/M	23b. Was decedent in the past 12 r 1 ☐ Yes 2	months?	4☐Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)	′				Month	Day Year
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ord	w require been si should t										10	Yes 2	MUNO 3□F	Probably 4 □Unknown
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o	Phys or this oral dir	\vdash	1 ☐ Yes 2 Det 27. Manner of Death		28a. Date of Inju	ont 2 ☐ ER/Ou ry 28b.]	Time of				me 5□ Resi 28d. Describe			өсігу)
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Division of	l or Attend after death Director: /	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ury - At home, fa	ırm, stre	eet, factory, office			28f. Location (City or To			Rural Route Number,
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	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b.	Med	29b. Signature and t	title of certifier	and manner sta	21 3 0.		29c. License	e numbe	r		29d. Da	te signed (Moi	nth, Day, Year)
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	λ		30. Name and addre	ess of person wh	o completed cause of d	eath (Item 23a)	(Type, I	Print)		/_/_		7	/ ~J,	
	Υ \		Alila	1-15im	4 March	VIII	_/-	1-1pita	1	Rane	17/10x	DAM	h	ary Bud
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	Registr	ar			Li A	was St	1	MARIE						

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State Registrar AMEND ITEM	State of Mai	ryland / De IRB FROM	epartment of l	lealth and I	Mental Hy H	giene 0 ()5	24415
Physic	ian	1. Decedent's Name (First, Middle, Last,					2. Date of De Month	Day	Year	3. Time of Death
/Medi	cal	Mary Olivia Skr 4a. Facility Name (If not institution, give			4h City Town o	or Location of Death	July_	22 2 4c. County	005 v of Death	9:37 A. M
Exami	ner	1840 Colmar Road			Woodl				1timo	re
Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birtho	day) If Under 1 Year Months Days		8. Date of Bir (Month, Da			lace (State or Foreign
Director		216-16-8711 Usual Residence of Decedent) M 2121 F	82 Yr	s.		June 4		Mary	
land		10a. State 10b. County		10c. City, Town o	or Location				1	0d. Inside City Limits
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th the or 28¢	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
ath wi	rai	1840 Colmar Road				21207			.A.	
ter de Itemi	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No	ver in U.S.	 Was Decedent of Interest of It Yes, specify Cub 	lispanic Origin? (S) an, Mexican, Puerti	pecify Yes or No Rican, etc.)	Bla	ce - Americ ick, White,	
urs af	by	3 ☐ Widowed 4 🏖 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specif	^{fy:} Whi	te
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Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)		Swit	ch Board O	perator 18. Mother's Nam	e (First, Middle	Custom Maiden Surnar		rvice
In yidilid 2 12 13 100000 2 should be filed within 72 hours after death with the Maryland and Menlal Hyglene. Is marked other than "naturel", or items 23s or 28e-f show aumatic event, the Madical Evapuration matter notified at	o Be	John Adam Zimmern	ıan				Cather			
	-	19a. Informant's Name/Relationship (Ty	рө, Print)	19b. N	lailing Address (Street	and Number or Ru	ral Route Numb	er, City or Town	, State, Zip	Code)
and 2 auth a saith a n 27 Is		Doris Gorman (Dau	ighter)		O Colmar R	oad Wood	-			
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hyglene. Importent: If item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other traumatic event, the Medical Evantment must be nutilled an once.	-	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other pla	сө)	Date	20c. Location	- City or To	wn, State
t. Pa rtmen rtent:		`4 □Donation 5 □ Other (Specify)		New Fre	edom Cemet	The state of the s	-2005	New Fre	edom,	PA
Depariment of the part of the		21. Signature of Funeral Service License	7/	- 1	22. Name and Addre	eral Home	of Cat	onsvill	e, In	.c.
THE TE		23a. Fart1. Enter the disease, or compli	cations that caused th	he death. Do not	1630 Edmon enter the mode of dyir	dson Aver ng, such as cardiac	or respiratory a	nsville rrest,	, MD	Approximate Interval Between
Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	le cause on each line.	Pin her	luna	GAND	1			Onset and Death
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eath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2	Fetal death	3 Ectopic pregnancy	/			ate of delive	ery Day Year
at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□ Unknown	me of death	5 ☐ Other (specify) _	 				•
gg pag		Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
quires n sign	ed by						10	Yes 2110	3 ☐ Prob	ably 4 Unknown
law requir as been si 2 should	ompleted						24a. Was	an 24b.	Were autor	psy findings available
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ilcian: Th	BeC	25. Was case referred to medical examiner?				26. Place of Dea				
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aling F	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	/ear) 28b. Tim Inju	ry Wor	y at k? Yes 2 □ No	28d. Describe i	now injury occur	rred	
Attend death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	/ - At home, farm,	street, factory, office	163 2 10	28f. Location (S	Street and Numl	ber or Rura	il Route Number,
al or /	Certific	4 Homicide	building, etc.		,		City or Tov	vn, State)		
To the Hospital or Attending Physicial To the Function of To the Function of Completely filled in by the funeral	edicai (xamination and/o	eath occurred at the tir r investigation, in my o					
Fo the vithin Fo the comple	Me	29b. Signature and title of certifier		-	29c. Licens	e number		29d. Date signe	ed (Month, I	Day, Year)
->		1/4/11	ille,		DOU	-971		7-2	5-2	005
\int_{Ω}		30. Name and address of person who con	mpleted cause of dea	th (Item 23a) (Ty	pe, Print)	·				
Ψ.	•	Dr. Miguel Heredia			nwealth Av	e Catons	ville,_	MD 2122	.8	
Sta Registr		JUL 2 6 2005	32. Registrar's	S Signature	de					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N6) 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Jack L. Spector 21 8:45 AM July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Genesis HealthCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ M 2□ F 84 138-01-4867 Director November 24.1920 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Talbot Easton Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 506 Hazelwood Drive or Itams 23a 21601 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify Specify: White 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Proprietor Army and Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Spector Rebekah Goldberg ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra Brian Spector/Son 506 Hazelwood Drive, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremato Crescent Me Park Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial 2005 4 ☐ Donation 5 ☐ Other (Specify) Pennsauken, NJ 22. Name and Address of FacilityBerschler, Shenberg and Blady Funeral Signature of Funeral Pervice Censee 5341State Highway 38, Pennsauken, NJ 08109 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. 14 (2/ + disease or condition resulting in death) 128 11000 /Medical Due to (r an a consequence of): **Examiner** Sequentially list conditions, if any, leading to intrindiate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ should be 2 No 3 Probably 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 autopsy performed? 1∐ Yes 2010 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 🗌 Yes 2 -110 2 ER/Outpatient 1 Inpatient 3□ DOA 4☐ Narsing Home 5 ☐ Residence 6 ☐Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After s after dec. 1 Natural 5 Pending investigation Injury 2 Accident 1 □ Yes 2 □No Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29d. Date signed (Mogth, Day, Year) Name and address of person who con pleted cause of death (Item 23a) (Type, Print) SANCHEZ, 508 DUEWIL 32. Re State 6 2005 Registrar

Jack Spector

**			~		gara
State of Maryland /	Department of Health and	d Mental Hygien 🕻 🕽) (J	C

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 6 25 AM Robert W. Shaw Month Physician 22 Tuly 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4810 Arabia Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Yea Aug 25, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 **X**XM 2 □ F 213-58-4494 55 Yrs. Aug 1949 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A XXYes 2□No **Baltimore** Director Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? **USA** death with 21209 2219 Rogene Drive Apt. 203 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Itame 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itan any hiury or other treumatic event, it e Medical Examintations. 1 ☐ Yes 2 XXX o If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1XXYes 2□ No Specify: Specify: Completed by 3 Widowed 4 Divorced Cuban white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hoffman Canvas S<u>alesman</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Curiel Dolores Shaw Wilton ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 Wilton Shaw (Father) 4810 Arabia Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KIX remation 3 ☐ Removal from State 7/24/05 Metro Crematory Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Baltimore, MD 23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between inset and Death Immediate Cause (Final disease or condition resulting in death) Malignant Melanoma Pnys**ici**an /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physiclen and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: esn n 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day ŏ in the past 12 months? Month Year 5 Other (specify) signed by the a P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) owents Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Rether (Specify) home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funerel D Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 2 024356 Watestida 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Weinberg Concent Institute at Franklin Ly Win C. WATERFIELD 9103 Franklin Ly Bolt 21237 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 2 6 2005 Registrar

			For State Registrer	State of Ma	-	epartmen Certificat			and M	ental Hy	giene ()	05	244	18
	Physici /Medi		Decedent's Name (First, Middle, La	Jol	nn L. Sh					2. Date of De Month July 2	4, 2005		3. Time of 5:00	
	Examir	er	4a. Facility Name (If not institution, given 3838 Roland Ave	enue Apt.		Ba	1tim					N/A		
	Funeral Director			Sex 7. Ag X.⊠M 2□F	e (In yrs. last birtl 72 Y	Months	Days	If Under: Hours	Min.	Feb. 1	th ly, Year) .3,1933	Cou	nplace (State or Intry) nsylvan	
	Maryland a-f show	tor	10a. State 10b. County Maryland N/A		10c. City, Town	or Location altimore)						10d. Inside City	·
	with the	Direc	10e. Street and Number 3838 Roland Aver	nue Ant	1111	10f. Zip	Code	212	1 1		10g. Citizen of	What Col	untry?	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23e or 28e-f show aumstic event, the Mudical Examiner must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2 AMarried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Deced	_			ecify Yes or No Rican, etc.)	- 14. Ra BI Spec	ice - Amer ack, White	ican Indian, o, etc. White	
Maryland 21215-0036	ithin 72 hour ne. nen "naturel	Completed t	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. I	Decedent's Usua (Give kind of wor life. DO NOT us	k done di e retired)	uring most	of worki	ng	16b. Kind of	Business/I	ndustry	
and 21	id be filed w ental Hygier ked other th ic event, the	o Be Cor	12 17. Father's Name (First, Middle, Last William Shroye)	•		Mac	hini	18. Mothe		(First, Middle	, Maiden Suma		ustry	
Mar	and 2 should alth and Men 127 is marke er traumatic	_	19a. Informant's Name/Relationship Elizabeth Shroyer	Турв, Print) (Wife)) 19b. 38:	Mailing Address 38 Ro1ar	(Street a	nd Numbe	or or Rura Apt	I Route Numb	өг, City or Town Baltin			211
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other traumatic once.		20a. Method of Disposition 1 ∑ surial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Service) Lices 21. Sign turn of Funeral Service Lices	(4)	cemetery	Disposition (Namer, crematory or o	ther place th		7/26,	/2005		erton	, Maryl	and
Ba	perm Depa Impo eny i		Jean !	legenter		Burgee- 3631 Fa	Hens	sorFacility SS-Se: Road	itz l Ba	Funeral Itimore	Home, Maryl	Inc.	21211	
	/Medical sician and burial-transit	Examiner	23a. Part. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (x) as b	tonsequence of the consequence o	leut	e of dying	he he	cardiac o	r respiratory a	rrest, 2000	2	Approximate Interval Betw Onset and D	veen leath
58760,	ficate be exemple such a such	dical	resulting in deathy East	d	a consequence of	n):								
.O. Box (The law requires that the death certificate be executed has been signed by the attending physician and vage 2 should be detached for use as the burial-trans	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pro	egnancy ecify)					ate of deliv		ear
ords, P	w requires that the deben signed by the should be detached	ted by P	Part II. Other significant conditions of	contributing to death be	ut not resulting in	the underlying co	use give	n in Part I.		23e. Did t			the cause of de	
Vital Records,		Completed				<i></i>				24a. Was auto perfo 1 Yes	an 24b psy primed?	Were aut prior to co death? 1 Yes	opsy findings a ompletion of ca	vailable use of
		To Be	25. Was case referred to medical examiner? 1 ☐ Yes ∠ No	Hospital: 1 ☐ Inpatie	nt 2 EP/Outp	patient 3 DO	Other			(Check only one 5 Flesi	one) dence 6 □Ot	her (Spec	ify)	
on of	iding Phys th. : After this s funeral di		27. Manner of Death Adural 5 Pending 2 Accident Investigatio	28a. Date of Injui (Month, Day	y 28b. Ti Yea <i>r)</i> Inj	me of 2. ury M	Bc. Injury Work' 1 □ Y	at ? es 2 □ N		28d. Describe	how injury occu	rred		
Division	= 15 fg €	Certification:	3 Suicide 6 Could not b	e 200 Place of Inju	ıry - At home, farr c. (Specify)	m, street, factory				28f. Location (City or To		iber or Rui	ral Route Numb	per,
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medical Examone)	nysicien: To the best on niner: On the basis of and manner sta	examination and	or investigation,	in my opi	nion, deat	d place, a	and due to the ed at the time,	date and place	, and due	to the cause(s)	
	To with	Z	29b. Signature and title of certifier	fuel	M		License	14 P	88		29d. Date sign	25 25	2005	
	Sta Registra		30. Name and address of person who some state of the sound address of person who some some state of the sound address of person who some some state of the sound address of person who some state of the sound address of person who some state of the sound address of person who some state of the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of person who so the sound address of the sound address of person address of the sound address of the	May 22 32. Poistra	eath (Item 23a) (T	Sparle	ovino	y le	M	Ba	(t) m	re,	MO 2	1210
0.1		01		J. W. G. C.	-	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2015 24419 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** IEN JANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR BALTIMORE CARE Koland lak If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2/4F **Funeral** 62 Yrs. Months MARYL Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28a-f show other traumatic event, the Medical Examiner roust be notified at 1 Yes 2 No Ockeys ville BALTIMORE Director 10g, Citizen of What Country? 10e. Street and Number USA 21030 or items 23a Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other treumatic event. The Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Harold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Water vantord Harry 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Forest Hill, 7-05 4 □ Donation 5 □ Other (Specify) EVANS FUNERAL CHAPEL-21. Signature of Funeral Service Licenses 22. Name and Address of Facility ALTI MORE, MD Z1234. Kimberly no Ca EVANS FUNERACHARA, 8800 HARFORD RO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Selevan **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner genderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es a consequence of) Examine sicien and burial-transit Degenentive Diseas The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 WNo
9 Unknown Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? iis certificate has director, page 2 2 1 No 2 No 1 🗌 Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 7/25/05 MD D31464 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8r Smt 308 Balt mi) 21201

DHMH 17 Rev 1/2001

State Registrar SITACHIZ

31. Date filed (Month, Day, Year)

A. HASHMIMD.

2 6 2005

32. Registrar's Signature

BZI N. ENTAW

State Registrar

31. Date filed (Month, Day, Year) JUL 2 6 2005

Greenberg

10 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Las-hak

Redstrar's Signature

MAD

M.D

29c. License number

OCME

29d. Date signed (Month, Day, Year)

July 18, 2005

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 Bernard Hewitt Smith 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Confer Rmini Boltimore Washin ton Medical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 X M 2 ☐ F 85 217-09-6008 Director 28,1919 MD Sept Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1677 Bayside Beach Road 21122 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Domino Sugar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o Roland Smith Sophia Fekays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Mr. Kenneth Smith / Son 1677 Bayside Beach Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 💢 9ther (Specify) mausoleum | Cedar Hill Cemetery 7-23-2005 Brooklyn, MD 21. Signature of Innant | Service Litenses 22. Name and Address of Facility Singleton Funeral HOme 1 Second Ave, SW; Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Com con 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 20 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Medical Certification; To Be Other: Hospital: ↑ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending 1- Satural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide completely filled in by determined within 24 hours a TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130

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State Registrar 31. Date filed (Month Pay, Xear) 2005

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32 Registrar's Signature

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	or 28s	Jirec	10e. Street and Number	424			10f. Zip Code		10	g. Citizen of What C	ountry?
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altimore,	of He		20a. Method of Disposition √Surial 2 ☐ Cremation		20b. I	Place of Dispo cemetery, crei	sition (Name of matory or other place	e)	Date 2	20c. Location - City o	r Town, State
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Ö	itel or irs efte rel Dir	Cert	4 E ROTTICIO	Dulk	ding, etc. (Speci	ry)			City or Town,	, State)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Phullis Smith 9226 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-38-2508 Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State wn or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Completed by Funeral Director timore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Items 23a 516 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Diac Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO QT se retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) e other traumatic event, ather's Name (First, Middle, Last) Be pe ပ Pages 1 and 2 should 19a Informant's Name/Relationship sister If item 27 I inia Baltimore, thod of Disposition ò Burial 2 ☐ Cremation 3 ☐ Removal from State parmit. Page Depertment of Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License reen 23a. Part1. Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seesis **Physician** /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? Yes 2 No certificate ! 1 ☐ Yes 2 ☑ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 ▼ No Certification: To 1 MInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. 1 Tes 2 No investigation ofter death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 | Homicide within 24 hours a To the Funerel C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of de th (Item 23a) (Type, Print) South Street Boltmore 22 Notoski peine 31. Date filed (Manth, Day, Year) 32. Registrar's Signature State Registrar

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	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, or Location of Death		c. County of Death				
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	Funeral Director		5. Social Security Number 185 - 12 - 950 6 Usual Residence of Decedent	1. Sex 7. Age (In Yrs. last bi	rthday) If Urider 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea MARCH 10,		place (State or Foreign intry)			
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ary	and M and M is mar	-	19a. Informant's Nam a Felationship	(Type, Print)	o. Mail g Address (Street and Number or Rura	l Route Number, City	or Town, State, Zij	o Code)			
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Baltimore	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or othar tr once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		of Disposition (Name of pry, crematory or other place)	ate 20c.	Location - City or T	own, State			
Ë	Pag tment tant: jury c		'4 □Donation 5 □ Other (Spe	city) GREEN,	Koust Cametery JULY	26,05 B.	AltiMor	e Macylania			
Bal	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Lic	censee	22 and Address of acility	INO JR.	Fund .	Home			
	10240		23a Part 1 Enter the disposal or co	omplications that caused the death. Do	not enter the mode of dying, such as cardiaco	5tree	+ BAlto	Approximate Interval Between			
	Paradalan I		Immediate Cause (Final	ny one cause on each line.	one cause on each line.						
7	Fnysician (/Medical		disease or condition resulting in death)	a. Chronic 10	Due to (or as a consequence of):						
				Due to (or as a consequence	of):			(10 asl.			
	Examiner				of):			y east.			
	Examiner	lner		b. Due to (or as a consequence				(eac.			
	Examiner and I-transit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b	of):			લ હન્ન.			
,09	be executed cian and purial-transit and	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):			લ હન્ન.			
68760,	ate be executed hysician and the buriat-transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	of):			લ હન્ન.			
9	ate be executed hysician and the buriat-transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence d. 23c. If yes, outcome of pregnancy	of):		23d. Date of deliv				
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of Vital Records, P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underfung states of light in that initiated events resulting in death) Last IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence c. Due to (or as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown s contributing to death but not resulting in Attendance Leafier Hospital: 1 Inpatient 2 ER/Or 28a. Date of Injury (Month, Day Year) 28b. Physician: To the best of my knowledgraminer: On the basis of examination ar	of): of):	24a. Was an autopsy performed? 1 Yes 2 N (Check only one) ne 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	Month o use contribute to to to 2 No 3 Protection 24b. Were autoprior to condeath? 1 Yes 6 Other (Special ury occurred)	ery Day Year the cause of death? bably 4 Unknown posy findings available empletion of cause of 2 No fy) al Route Number.			
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of Vital Records, P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence c	of): of): a 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given in Part I. OF Part Of Discourse 26. Place of Death utpatient 3 DOA Other 4 Nursing Hon Time of Injury at Work? M 1 Yes 2 No arm, street, factory, office e, death occurred at the time, date and place, a ad/or investigation, in my opinion, death occurred 29c. License number	24a. Was an autopsy performed? 1 Yes 2 N (Check only one) ne 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	Month o use contribute to to to to to to to to co death? 10 Other (Special ury occurred and Number or Rurate) s) and manner as sind place, and due to the total	ery Day Year he cause of death? bably 4 Unknown posy findings available impletion of cause of 2 No fy) al Route Number, stated. o the cause(s) Day, Year)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** July 23, Mary Jane Shisler 9:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 Deacon Brook Circle Baltimore Reisterstown 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 31,1906

9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1 □ M**XX** F 192-34-2353 98 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r Items 23a or 28e-f show shermast be notified at 10d. Inside City Limits Be Completed by Funeral Director Baltimore Reisterstown 1 ☐ Yes 🏋 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 Deacon Brook Circle 21136 U.S.A. filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes XX No Specify: XXWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Elementary School Teacher Education Pages 1 and 2 should be filed vitnent of Health and Mental Hygientent: If Itam 27 is marked other thury or other treumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Byers Mary Ann Ausherman ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type, Print) Barbara Carr / Daughter 508 Deacon Brook Circle; Reisterstown, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Department of H Importent: If Its any injury or ot once. An firm Menylohipe XX Buriai 2, Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Church Cemetery 7/27/05 Green Castle, PA. of Fun I Service 21. Signatu 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart faifure. List only one cause on each fine. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) Mes /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 DEctopic pregnancy þ Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy 21 No 1 Yes Hospitel or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl. one 2 Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Statural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deati To the Funerel Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the ! 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar

			1- State Amend Item 3	State of Maryland / D 0 per dvrG845 7-26	epartment of I	Health and M	Mental Hygier	2005	24427
	Physici	an	1. Decedent's Name (First, Middle, La			2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	HELEN 4a. Facility Name (If not institution, gire	GANS	SENKE	R or Location of Death	JULY 24	2005 4c. County of Deat	1:40 A M
	Examir	ier	LEVINDALE HEBREW		BALTIMO			4c. County of Death	N/A
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last birth	Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye, 12/16/191	ar) 9. Birti	hplace (State or Foreign
L	Director		Usual Residence of Decedent	10 M 2 M F 87 Y	rs.		12/16/191	.7	VA
	yland how		10a. State 10b. County	10c. City, Town	or Location		•		10d. Inside City Limits
	8a-fs	Director		I/A BALTIMO					1 Yes 2 □ No
	with the or 2		10e. Street and Number 6316 CDEENCODING	G AVENUE APT. #203	10f. Zip Code 21209			Citizen of What Co	untry?
	death	Funeral	11. Marital Status	12 Was Decedent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-	J.S.A. 14. Race - Amer	
36	hours after death with the Marylan tural; or Itams 23a or 28a-1 show at Examiner must be notified at	by Fu	1 Never Married 2 Married	Amed Forces? 1 □ Yes 2 🐧 No If Yes, Give	1 ☐ Yes 2 🕅 No	oan, Mexican, Puèrto Specify:	Hican, etc.)	Black, White	e, etc. IITE
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jisal Evartinat must be notified at		3 ሺ Widowed 4 ☐ Divorced	Year or Dates:	Decedent's Usual Occu		16h	. Kind of Business/I	
215	C * 39	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	(Give kind of work done life. DO NOT use retire	during most of work	ring	Tring of Eddinosari	ridustry
121	ba filed withintal Hygiene. Id other than event, Ite M		12 17. Father's Name (First, Middle, Las.	L1	IBRARIAN	40.44.1.4.4.			BREW SCHOOL
Maryland		To Be	WALTER	JOSEPH	GANS	LUCILE	e (First, Middle, Maid		TEIN
	d 2 s th ar 7 is trau		19a. Informant's Name/Relationship ALLAN SENKER / S	77 7	Mailing Address (Street 106 GARRISO				
Baltimore,	of of or or		20a. Method of Disposition 1	Removal from State cemetery	Disposition (Name of crematory or other pla	ce)		Location - City or 1	
Itim	permit. Pag Department Important: I any injury o		' 4 ☐ Donation 5 ☐ Other (Special Signature Lice Lice Lice Lice Lice Lice Lice Lic		FRIENDSHIP 22. Name and Addre		5/2005 BAL LEVINSON		
Ba	permit. Departm Importa any inju		Mucha	1 Deugen	8900 REIST	ERSTOWN R	OAD - PIKE	SVILLE,	MD 21208
П	1		23a. Part1. Enter the disease, or con shock, or heart failure. List only		Approximate Interval Between				
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metasta	tic Colo	in Cau	ncer		Onset and Death
ı	Examiner			Due to (or as a consequence of					
	₽ ≓	ner	Sequentially list conditions, cause. Enter Underlying	Due to for as a consequence of					
	ecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dlcal E	l	. d	·/·				
9	rtificati ng phy as the	Medic	In return 6						
Вох	eath certific attending p I for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mponths?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnanc	y		23d. Date of deliver Month	very Day Year
0	t the de by the a tached f	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)				July 10ai
ο,	es that igned b	by Pr	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ords	v require been sig should b						1 ☐ Yes	2 → 10 3 □ Pro	bably 4 🗀 Unknown
Vital Records,	e lav has je 2	ompleted					24a. Was an autopsy performed?	24b. Were aut prior to co death?	topsy findings available ompletion of cause of
tal		o C	25. Was case referred to medical			26. Place of Deat	1 Yes 2		2 No
of Vi	Physician: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Ott	or A /	me 5 Residence	6 ☐Other (Spec	ify)
	ing After une	lon:	27. Mapper of Death 1 Natural 5 Pending		ury Wo		28d. Describe how in	jury occurred	
Division	art or:	ertiflcation:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farr		Yes 2 □No	28f. Location (Street	and Number or Rui	ral Route Number,
Ö	tal or rs afte al Dira	O	4 Homicide determined	building, etc. (Specify)		City or Town, Sta	ite)		
	To the Hospital or Atti within 24 hours after de To the Funaral Diracto completely filled in by th	ledical	29a. Certifier 1 Certifying Pl	nysician: To the best of my knowledge, miner: On the basis of examination and/ and manner stated.	death occurred at the till for investigation, in my o	me, date and place, opinion, death occur	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	200 U 1	29c Licens	se number	29d. [Date signed (Month,	, Day, Year)
	4		1 Hun	Mysh/10	V53	743	7	124/05	
1	0		30. Name and address of person who	completed cause of death (Item 23a) (T			/		
	Sta	te	31. Date filed (Month, Day, Year)	Susan M. Levy 32 Registrar's Signature	Levindale	Hebrew Ho	ome Baltim	ore, Md	
	Registr		JUL 2 6 21	005 Junear As	GOODS !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician FLORENCE** 20, SIEGEL JULY 2005 1:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2928 NORMANDY DRIVE ELLICOTT CITY HOWARD 8. Date of Birth (Month, Day, Year 07/13/1909 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2**X**☐ F Yrs 217-05-6213 96 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "netural", or Items 23e or 28e-f show If e Madical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director HOWARD ELLICOTT CITY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2928 NORMANDY DRIVE 21043 <u>U.S.A.</u> Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12College (1-4or 5+) ADMINISTRATOR CITY OF BALTIMORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be MAX SIEGEL ೭ SARAH EINHORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BISHOFF / NEPHEW 10331 WILDE LAKE TERRACE - COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) WORKMAN CIRCLE 07/24/2005 BALTIMORE, MD 21. Signature of Juneral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. once. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 13 chemic heart disease Physician 30 years disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner artherosclerosis Years Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto (or as a nonsequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 YNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 V Residence 6 Other (Specify) 1 Yes 2 No ٩ 3 DOA 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Injury s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Registrar

one)

29b. Signature and title of certifier

3 MAY

31. Date filed (Month, Day, Year)

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

6 2005

5900

32. Registrar's Signature

MILLES

Cedu-

MID

29c. License number

DS 6651

Columbia

29d. Date signed (Month, Dev. Year)

MV

ON	SCOTT			State of Maryland / Depa 23a,27,28a-f per me		Mental Hygien	ne .					
					difficate of Death as							
	Physici	an	1. Decedent's Name (First, Middle, La	st)			3. Time of Death 5: 28 P M					
	/Medic Examin		Don D. Scott 4a. Facility Name (If not institution, given MERCY HOSPITAL)	re street and number)	4b. City, Town, or Location of Dea	JULY 18, 2005 5:28 4b. City, Town, or Location of Death BALTIMORE CITY 4c. County of Death						
	, Funeral		Social Security Number 6. S	Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr		9. Birthplace (State or Foreign Country)					
5	Director	ā I	216-94-9494 Usual Residence of Decedent	1☐M 2☐F 39 Yrs.	Months Days Hours Mir							
,	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
	deeth with the Maryland me 23a or 28a-f ehow rinust be notified at	ģ	MD	Baltimo	re		1X Yes 2 ☐ No					
	or 288	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?					
	th wit		814 Showell Ct	•	21202	US	A					
	r dee	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Tovorced	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify:Black					
0	within 72 hours after ene. then "natural, or ite	ed b	15. Decedent's E	Year or Dates:	tent's Usual Occupation	16b	Kind of Business/Industry					
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212	d with giene	E O	Elementary/Secondary (0-12) 12th	College (1-4or 5+) Labe	orer	Wa	Eehousing					
bu	be filed within tal Hygiene. Id other then event, the Mener the me	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maide						
yla	should be filed within and Mental Hygiene. marked other then matic event, Its M	2	Larry Scott Sr			a Mitchell						
Maryland 21215-0036	es 1 and 2 should b of Health and Ment fitam 27 is marked r other traumatic e		19a. Informant's Name/Relationship (ng Address (Street and Number or F							
é	l and fealth im 27 her ti	1	Babara Mitchell		Showell Ct. Ba							
Baltimore,	O		20a. Method of Disposition 1 Deurial 2 Cremation 3	Jramoval nom State	sition (Name of natory or other place)		Location - City or Town, State					
Itim	permit. Pag Department Important: eny injury o		4 Donation 5 Other (Special	A A		26-05 Du	ndalk,MD					
Ba	Depa Impo eny i		21. Signature of Funeral Service Licer	Was II.	Name and Address of FacilityWe	sley Chav	is Jr. FH					
ć	- 36		23a. Part1, Enter the disease, or com	plications the caused the death. Do not ent one cause on each line.	007 Eastern Av		MD 21231 Approximate					
	Physician /Medical Examiner pnual-transit	aminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cocaine intoxicati Due to (or as a consequence of): b	on		Onset and Death				
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687	ficate physics the			d								
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ds, P	uires thai signed t Id be det	by	Part II. Other significant conditions of	contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
COL	w requir been si should	Completed				24a. Was an						
Re	sician: The law certificete hes t irector, page 2 s	E O				autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
tal		0	25. Was case referred to medical		26 Place of De	1 1 Yes 2 □ N eath (Check only one)	lo 1A Yes 2□ No					
>	Physician: r this certificatal director.	ToB	examiner? 1∭ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatien	Othor	Home 5 ☐ Residence	6 ∏Other (Specify)					
Division of Vital Records,	ding h. Afte fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found th, Day Year) 7 19 05		28d. Describe how inju						
Divis	P # F	Certification:	3 Suicide 6 XCould not b 4 Homicide determined	O One Place of lainer At home form street from		28f. Location (Street and Number of Fural Route Num City or Town, State) 1500 Block Hai Road, Baltimore, Md						
	ne Hospital n 24 hours ne Funerel bletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my knowledge, death niner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place estigation, in my opinion, death occ	e and due to the cause/	s) and manner as stated					
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	hall, MD	29c. License number O.C.M.E		ate signed (Month, Day, Year) ILY 19, 2005					
			30. Name and address of person who Pamela E. Bord	completed cause of death (Item 23a) (Type, Hall, MO 111 P.	Print) ENN STREET, BALT	IMORE, MARYLA	ND 21201					
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 2005 32. Restrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 7 1 1 5 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 1:50 PM **Physician** July Shirley Mae Thomas 21 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 17, 1946 9. Birthplace (State or Foreign Country).
New York 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 🕅 F 069-38-2947 59 Yrs. Apr Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director New York Kings Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 455 Jefferson Avenue 11221 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hallie Spann Willie Mae Miggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yedidah Spann, Daughter 470 Lenox Avenue Art.9J New York, NY. 10037 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 07/22/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Vensee Cremation Society Of Maryland, Inc. Inomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer -AD Vanced OVariAN Physician 8 maple disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion was ause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Sether (Specify) Hospico 1 ☐ Yes 2 → 10 1 Inpatient 2 EN/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Il Director: A investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

07.21.2005@1350 HOMAS, To the Hospital within 24 hours a To the Funaral Completely filled Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057740 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21286 1 ourser MO 8501 240 La Salle Rd 602 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar DHMH 17 Rev 1/2001

		-	For State Registrar		partment of Health are ertificate of Death	Reg. N	2005 24431			
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	/Medic Examin	er	TO CODOTTO DO TO	omE	4b. City, Town, or Location of LOCHEARN (1) If Under 1 Year If Under 2		4c. County of Death BALTIMORE 9. Birthelene (State of Foreign			
	Funeral Director		5. Social Security Number Color	7. Age (In yrs. last birthda) Yrs.	Months Days Hours	Min. (Month, Day, Yea 12.14.1913	9. Birthplace (State or Foreign Country)			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manial Hygiene. Department of Health and Manial Hygiene. Inportent: I flem 27 is marked other than "natural", or items 23a or 28e-f show important: I flem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic svent, IT a Marylast Ex., unit in ust be notified at once.	or	10a. State 10b. County	10c. City, Town or BALTIMOR			10d. Inside City Limits 1 ⊠ Yes 2 □ No			
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		by Funeral Director	11. Marital Status 12. Was De Armed	recedent Ever in U.S. 13 Forces? s 2 M No Give	Was Decedent of Hispanic Original Mexican, Mexican, 1 Yes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK			
21215-0036	within 72 hou ene. than "natura ne Madical E	Completed	2 1 2222	(Given (1-4or 5+)	edent's Usual Occupation re kind of work done during most of DO NOT use retired)	of working	Kind of Business/Industry DOMESTIC			
land 2	uld be filed within flental Hygiene. rked other than " tic svent, It a Me	To Be Co	17. Father's Name (First, Middle, Last) JOHN THOMAS			s Name (First, Middle, Maid E JOHNSON	len Sumame)			
Maryland	alth and Nath	19a. Informant's Name/Relationship (Type, Print) MARSHALL TAYLOR (SON	1	iling Address (Street and Number WICKLOW ROAD	or Rural Route Number, Cit BALTO. MD	y or Town, State, Zip Code) 21229				
Baltimore,	Pages 1 an ent of Hea ht: If item 3 ry or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal fro 1 □ Donation 5 □ Other (Specify)	m State 20b. Place of Dis cometery, ci	ematory or other place)		Location - City or Town, State			
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility AUGHN C. GREENE 151 BALTO. NATUPIL	E, BALTO, MD	21229			
0	the burial-transit		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	t caused the death. Do not en each line.	nter the mode of dying, such as c	ardiac or respiratory arrest,	Approximate Interval Between Onset and Death			
8760,		Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underfying Cause (Disease or injury that initiated events c.	to (or as a consequence of):						
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Division of Vital Records,	The law require cate has been si page 2 should I	Completed				24a. Was an autopsy performed 1 □ Yes 2 🖺				
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? Hospital:	☐Inpatient 2☐ER/Outpat	Other	of Death (Check only one) sing Home 5 Residence	6 (Tother (Specify)			
on of	Attending Physician: ir death. ector: After this certification by the funeral director, in	tion: To	tion: To	tion: To	tion: To		te of Injury 28b. Time onth, Day Year)	of 28c. Injury at	28d. Describe how in	
Divisi	of or Attentiated after the attention of the color of the	ertifica	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, ilding, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)			
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	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	290.	Date signed (Month, Day, Year) Suly 21,7005			
	1/		30. Name and address of person who completed of	25 Main 5	+ Reitenta	IS all na	1136			
	Sta Regist		31. Date filed (Month, Day, Year) 2 6 2005	Registrar's Signature	South					

			For State Registrer	State of M	1arylan	•	artment			and Me		ene 2005	24432)
			Negistrer Necedent's Name (First, Middle, La	st)						2	. Date of Death		3. Time of Death	
	Physicia		ROY E.	TAYLO	3					יד	ULY 20	, 2005 Yea	7:24 p ^M	1
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number	r)		4b. City,	Fown, or	Location o	of Death		4c. County of De	ath	
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	or 28	Director	10e. Street and Number				10f. Zip				10	g. Citizen of What		
	ath w	ral	2902 MALLVIEW				<u> </u>		1230			U.S.		
	er de Items	Funeral	11. Marital Status	12. Was Deceden	?	S. 13.	Was Deced If Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	Black, W	nerican Indian, nite, efc.	
36	irs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates	:1951	-57	1 ☐ Yes 2	X No	Specify:			Specify: W	HITE	
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pul	be fill Hall Hall doth	Be	17. Father's Name (First, Middle, Last KENT TAYLOR)								aiden Sumame)		
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П	/Medical Examiner		resulting in death)	Due to (or a	saconsequ	uence of):	1-			1 '				
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Вох	death certifical e attending phy od for use as th	an/N	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy				23d. Date of o	-	
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant 9□ Unknown			Other (sp					Month Day Year		
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions	contributing to death	hut not ree	ulting in the u	nderlying c	ause aive	an in Part I		23e Did tob	acco use contribute	to the cause of death?	_
ds,	es De	l by	S CAMPO C	Doink	540	1/con	1000	Δ.	dis	PIL			Probably 4 Dunknown	n
Record	w requir been si should	Completed	CO	2-1-1	-		11023		1	aux	24a. Wasan	24h Were	autopsy findings available	
Rec	The law cate has page 2 t	mp	Krow Ul	some	ine	june	MAN	arry	1 de	44VI	autopsy . periorm	ed? prior t	o completion of cause of	
Vital		e Co	25. Was case referred to medical					0	26 Place	of Death /	Check only one	No 14Y	es 2 No	
S	S S =	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Dinpa	fient 2 🗆	ER/Outpaties	nt 3 🗆 DO	A Othe	or:			nce 6 Other (S	Decify)	
) of	g Phy ter thi		27. Manner of Death	28a. Date of In	ijury	28b. Time o		8c. Injury Work				v injury occurred		
Sior	Attending ir death. ector; After by the fune	atlc	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	n			М		Yes 2 🗌	No				
Division	al or Attend after death I Director; d d in by the f	Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place of t	njury - At ho efc. <i>(Specif</i>)	ome, farm, sti	eet, factory	, office		28	If. Location (Str. City or Town,		Rural Route Number,	
	urs at urs at srai D		and a sittle of the state of th	hyddian Tolk ha	-4 -6		<u> </u>	- 4 44 - 41		d = ===================================	of alice to the con-	(a) and manned	as stated	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After completely filled in by the funer	edical		hysicien: To the bes miner: On the basis and manner:	of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0			290	. License	number	- 1	29	d. Date signed (Mo	nth, Day, Year)	
)	->=0		> Sylver, M.	D. 2			1	30C	605	501	-	July 22	-12005	
	1/2		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print)	Α		0	AT	7		
,	1.01		JOHANZ YOUS	1-	30		and	pla	u	Sa	Ulumor	L, MD	21202	
	Sta Registr		31. Date filed (Month, Daly, Year) JUL 2 6 2	_	strar's Signa	B. A	auli	,						

			For State	State of Maryland / Dep.	artment of Health and rtificate of Death	Mental Hygien	000 ===================================
			Registrar 1. Decedent's Name (First, Middle, Las		Timodio or Bodin	2. Date of Death	3: Time of Death
	Physici		Marie	T. Jaorm	ina	Month D	4, 2005 4:10 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give Saint Joseph	street and number)	4b. City, Town, or Location of Deat		c. County of Death Baltimore
	Funeral Director		010-02-9040	7. Age (In yrs. last birthday, M 2 AF Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) MARYLANO
1	within 72 nouts atter death with the Mayland jene. Then "natural", or items 23e or 28e-1 show the Medical Examinar must be notified at	or.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	rect	10e. Street and Number	MORE DE	10f. Zip Code	10g. C	Citizen of What Country?
	38 or	by Funeral Director	2909 Andorra	C+ AntD	21234		USA
	BE CONTROL	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or the	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 Yes 2 No Specify:		Specify: 116
215-0036	tural'	q pa	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	dent's Usual Occupation	16b.	Kind of Business/Industry
15	n na	Completed	(Specify only highest gra	de completed) (Give	kind of work done during most of wo DO NOT use retired)	rking	7
-		E	Elementary/Secondary (0-12)	College (1-4013+) Tell	'eR	13	SANKing
	be filed tal Hygid d other event, t	Bec	17. Father's Name (First, Middle, Last)	011	18. Mother's Na	me (First, Middle, Maide	en Surname)
yla	Men Men arke	၉	John- Greer	The base of the same of the sa	Cliza	beth H	artman
Maryland	z should had had had had had had had had had ha		19a. Informant's Name/Relationship (7	0	ing Address (Street and Number or Ri	ural Route Number, City	or Town, State, Zip Code)
	s 1 and f Health ltem 27 other t	1	20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20c.	Location - City or Town, State
Baltimore	0 0		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	matory or other place)	27158	ALTIMORE MD
ltin	그 두 뭐 글		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		2. Name and Address of Fac ity	ALTIMORE	mo 21234.
Ba	Departi Departi Import any inj once.		Janderly (Butnothy E	VALUS FOUR ERAL		SWHARFORD RD.
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only	pications that caused the death. Do not en	ter the mode of dying, such as cardia		Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	CEREBROVASCULAI	R THROMBOSIS		Onset and Death
4	/Medical		resulting in death)	Due to (or as a consequence of):			
1	Examiner		Sequentially list conditions,	ATRIAL FIBRILLA	ATION		
<i>\</i>	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
Α.	sicien and burial-transit	xan	that initiated events resulting in death) Last	c			
8760,	ate be e hysicier the buri			d			
68	Ine law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical					
Вох	Jeath certifica attending pt a for use as ti	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery Month Day Year
). E	it the dea by the at tached fo	slcl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 5[9☐ Unknown	Other (specify)		Month Day Tour
P.O.	natin ad by detacl			ontributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	ures that signed to d be det	d by	•			1 ☐ Yes	2 No 3 □ Probably 4 □Unknown
Vital Records,	been si should	Completed				24a. Was an	24b. Were autopsy findings available
Re	ine lav ate has page 2	шo				autopsy performed?	
		a)	25. Was case referred to medical		26. Place of De	1 Yes 2√N ath (Check only one)	10 103 24110
>	di S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatie	nt 3□ DOA Other: 4□ Nursing H	dome 5 ☐ Residence	6 ☐ Other (Specify)
			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	ury occurred
sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	-	M 1 Yes 2 No	COS I continu (Chant	and Number of Chief Courts Number
Division	al or Attend s after death al Director: /	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or At within 24 hours after of To the Funerell Direct completely filled in by	edical (ysicien: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.			
:	vithin To th	Me	29b. Signature and title of certifier		29c. License number	29d. D	Pate signed (Month, Day, Year)
)			- Zegrada P	media m.c	D41410	Sul	7 24007, 2007.
	10		30. Name and address of person who	completed cause of death (Item 23a) (Type	, Print)		
	Ψ			TA.M.D. 7601 08	SLER DRIVE TO	SON, MARY	/LAND 21204
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature			

Levi Andre White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 05-04901 24434 For State Registrar RPD 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2005 July 20, **Physician** 0233 A Levi Andre White /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□M 2□F Months 220-64-9415 49 Director 30, 1955 Maryland Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28e-f ehow Maryland the Medical Examiner must be notified at N/A Baltimore 1. Yes 2 No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 819 Newington Ave 21217 USA Itеля 23а death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "naturel", or them eny injury or other traumatic event, the Mental on once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify:Black 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Compl College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator Private Industry Year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Levi White Lucille Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita L. White/ Wife 819 Newington Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State King Memorial Park 7/25/05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Hom 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service License Funeral Home No 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gunshot wound **Physician** to disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the daath certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of deam?

1 Yes 2 □ No 24a. Was an 1XYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No in s After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death police Certification: Subject shot by 1 Natural 5 Pending 19:54 7/19/05 1 Yes 2 No within 24 hours aftar death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) fillad in by tactory 6320 Ochleaf Ave, Baltimore, MD 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. July 21, 2005 illa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ABIULLAH 22. Registrar's Signature 31. Date filed (Month, Day, Year) State market 2 6 2005 Registrar

			For State Registrar	State of M	1arylan		artmen rtificate					giene	05	24435
Г	Physici		Decedent's Name (First, Middle, Last, Hugh Robert								2. Date of Dead Month July		2005	3. Time of Death 10:30P M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number					Location	of Death	July	4c. Cour	nty of Death	<u> </u>
			512 Limerick Cir 5. Social Security Number 6. Sec			ast birthday)	Ti If Under	moni	um If Under	24 Hrs	9 Data of Bird		Baltin	
	Funeral Director		217-18-9655 X	M 20F	85		Months	Days	Hours	Min.	8. Date of Birt (Month, Da Nov 13,	1919	Cou	place (State or Foreign ntry) y Land
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	Maryland Baltimon	ce :		Timo	nium							1 ☐ Yes 2 🛣 No
	or 28	Funeral Directo	10e. Street and Number				10f. Zip					10g. Citizen o	f What Cou	ntry?
	eath v	eral	512 Limerick Circ	Le, #202 12. Was Deceden	t Ever in II	S 13 V	Nas Decod	2109		igin? (Sp.	orfu Voc or No		USA ace - Ameri	and Indian
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-1 show aumatic event, the Madical Evantize rinust be Incilling at	Fun	1 Never Married 2 Married	Armed Forces 1 X Yes 2 [If Yes, Give	$^{?}_{1No}$ 194	-					ecify Yes or No- Rican, etc.)		lack, White,	etc.
003	urat', c	d by	3 Widowed 4 Divorced	Year or Dates:	194		1 □ Yes 2		Specify:			Spec	ity: Wh:	ite
-51	in 72 l	plete	15. Decedent's Edu (Specify only highest grade	e completed)		16a, Deced (Give life, L	dent's Usua kind of wor DO NOT us	k done d e retired	ation <i>furing</i> mos:)	t of worki	ng	16b. Kind of	Business/In	ndustry
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	be file	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		ame)	
Maryland	should nd Men marke umatic	은	Hugh J. Wanke 19a. Informant's Name/Relationship (Ty	roe. Print)		19b Mailin	n Address	(Street a			n M. Do		n State Zi	2 Code)
	1 and 2 s Health an tam 27 is		Margaret T. Wanke,	*										and 21093
ore,	of Heam		20a. Method of Disposition 1 Burial 2 X Cremation 3 B	amoval from State	20b. P!	lace of Dispo	sition (Nam	e of ther place	9)		ate	20c. Location		
Baltimore,	t. Pages rtment of I rtant: If it	21. Signature of Funeral Savida isensee 28. Name and Address of Facility											Maryland	
Bal	permit. Departr Imports any inju	299 Frederick P							ěty (Road	Of Mary	land In	nc.	nd 21228	
r	8 · *	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.								cardiac o	r respiratory ar	rest,	ir y rai	Approximate Interval Between
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a											Onset and Death	
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8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial transit	dlcal E		Due to (or a:	a consequ	ierice oij.								
9	rtificate ng phys as the		IE EEMALE.											
Вох	leath certifica attending ph I for use as th	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Fetal	death 3 [Ectopic pre	gnancy					ate of delive	ery Day Year
ó	that the de ed by the a detached f	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	ath 5□	Other (spe	ecify)					iona i	Day real
Δ.	signed b	by Pr	Part II. Other significant conditions con	tributing to death	but not resu	Iting in the un	nderlying ca	use give	n in Part I.		23e. Did to	bacco use co	ntribute to th	ne cause of death?
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	~ M		1 Sohut) m	ejen			D	005	6 41	9	9	07/2	5/05	
			30. Name and address of person who co Robert B. Donegan M.D.	•				te 20)5 West	Balt	rimore. Ma	arvland	21204	
*			31 Date filed (Month Day Year)	22 Poplint	rar's Signar	4 Ag	and I						T	
4	Registr	State Registrar JUL 2 6 2005 32 Begistrar's Signards												

State of Maryland / Department of Health and Mental Hygien 2005 24436 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Wesley Sadie Uhs 82005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN NA If Under 24 Hrs. 8 HOSPITAL Date of Birth (Mpnth 3 Pay, 40ar) 9. Birthplace (State or Foreign Country) MA Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2XF 215-64-9482 65 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "neturel", or Items 23e or 28e-f ehow X Yes 2 No Baltimore Director Md NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 6000 Bellona Ave. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black à 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "ne any Injury or other treumatic event, Ille Made. nentary/Secondary (0-12) College (1-4or 5+) Other People Homes 10th grade Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilson Janie UNKn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3031 Robinhood Drive, Hinesville, Ga. Daughter Janie Washington 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. Date 20a. Method of Disposition 20c Location - City or Town State 1 Durial 2 Cremation 3 Removal from State 7-23-05 Dundalk, Md. * 4 Denation 5 ☐ Other (Specify) 21. Sgnatus of Funeral Service Licensie Baltimore, Md. 22. Name and Address of Facility 1101 E. North Ave. March F.H. East Part J. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distance or condition resume in death) MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö the detached 9 Unknown 9 Unknown signed by I ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Upknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 2 No 1 Tas 1 Yes Division of Vital 25. Was case referred to medical examiner?
1 Tyes 24 No 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Inpatient 2 ☐ ET/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 1 Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after ö within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Glei LUCH RAVEN BLUI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHARAN KALATHIL BAKTINERE, 1711) 21259 31. Date filed (Month, Day Year) 32. Register's Signature State 6 2005 Registrar Sounda

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TAZCL 142) Month Day 2005 055 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) _ 92 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 T F Months Hours Yrs. Director 217-26-1018 25, 1912 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mactical Examinar must be redified at Directo 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5400 Vantage Point Road 21044 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If Item 27 is marked other that any injury or other traumatic event, that once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter A. Hopkins Camila Selby ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Jennings Willey/son 124 Forest Drive Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 7/26/05 ^ 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Fungral Service Licensee 7
Thomas Gregor Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician TyperTensine TRANI disease or condition resulting in death) /Medical Due to as a consequence of) Examiner Sequentially list conditions, Due to (or se a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 2 No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No after death Director: 6 Could not be determined 3 Suicide n 24 hours after de • Funeral Directo letely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a v addres o person who completed cause of death (Item 23a) (Type, Print) PIENER 11055 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygie 20 0 5 24438 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 23, Loretta E. Ward July 1:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town or Location of Death Examiner Baltimore 4013 Silvage Road Baltimore 8. Date of Birth (Month, Day, Year) 1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F 79 Yrs. Maryland 219-10-0332 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23e or 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, the Medical Exercities is uset by notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 Silvage Road 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Snecify 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Insurance 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ditzel Loretta Cecelia Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Ward (daughter) 4013 Silvage Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any injury or o once. 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Parkwood Cemetery 7/25/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiovas aulae Alseasa **Physician** Arkeriosch disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner rstive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perhoidemice performed? this certificate 1 Yes 25 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient | 2 | EP/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/o investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20030717 Name and address of person who completed cause of death (Item 23a) (Type, Print) M.B. 6701 N Chaeles St. Suite 5201 Coul 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State 2 6 2005 Registrar

			Ple	ase Type or				Health and	-		egible.	
			For State Registrar	State 0	i waiytan		rtificate of		Wichtairiy	Reg. N2	105	21.1.20
			Decedent's Name (First, Middle)	die, Last)					2. Date of D	ath		3. Time of Death
	Physicia		Ernest Andrew	Watkins					Month 7	13	2005	20:21 p ^M
	/Medic Examin		4a. Facility Name (If not instituti	on, give street and nur	mber)		4b. City, Town,	or Location of Dea	ath	4c. Co	unty of Death)
			Southern Maryl	and Hospit	al Cent	er	Clir			1	nce Geo	
	Funeral Director		5. Social Security Number 578680109	6. Sex 12€ M 2 ☐ F	7. Age (In yrs.	last birthday) 55 Yrs.	If Under 1 Yea Months Days			/1950		place (State or Foreign intry) ington, DC
	pur *		Usual Residence of Decedent 10a. State 10b. Count	tv	10c. Cit	y, Town or Lo	ecation					10d. Inside City Limits
	72 hours after death with the Maryland Inetural; or Items 23a or 28e-1 ahow Jisal Examiner must be notified at	ō		e George's	IIn	per Ma	rlboro					1 ☐ Yes 2 ☐ No
	28e-	Director	10e. Street and Number	e deoige s		per Ma	10f. Zip Code			10g. Citizer	n of What Cou	untry?
	3a or	Ϊ́	9722 Green A	pple Turn			207	72			USA	
	death	by Funerai	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? ban, Mexican, Pue	Specify Yes or N	0- 14.	Race - Amer Black, White	
9	after or Ite	J.	1 ☐ Never Married 2 ☐ Ma	arried 1 🗗 Yes	2 No 19/	U	1. Tes, specify ou 1. Tes, specify ou		orto i nocin, oto.)		Black, William	
8	72 hours aft "netural", or		3 Widowed 4 Divorce	ed Year or D	ve lates: 197	2						
7	"net	iete	15. Decede (Specify only high	ent's Education lest grade completed)		16a. Dece (Give	dent's Usual Occu kind of work don DO NOT use retir	spation e during most of w ed)	orking	16b. Kind	of Business/I	ndustry
12	within ene.	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		ity Supe	*		Federa	al Gove	ernment
d 2	filed Hygid other ent.	Be Co	17. Father's Name (First, Middle	e, Last)				18. Mother's N	ame (First, Middle	, Maiden Su	ımame)	
lan	should be nd Mental marked o	To B	Ernest Watkin	S				Laura	Braxton			
Maryland 21215-0036			19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address (Stree	et and Number or i	Rural Route Numb	per, City or T	own, State, Z	ip Code)
	Health a tem 27 is		Deborah Watki	ns/Wife				ple Turn	The second second			
ore	0 0	l i	20a. Method of Disposition 1 A Burial 2 Cremation	3 Aremoval from	C1-1-	cemetery, cre	osition (Name of matory or other pl	ace)	Date		tion - City or 1	
Ë	Pages tment of I tant: If its jury or o		Donation 5 Other	(Specity)	Cn		am Vet.		21/2005			
Baltimore,	permit. Pag Department Important: I any injury o	Deborah Watkins/Wife 9722 Green Apple To 20a. Method of Deposition 1 A Buriar 3 Cremation 3 Premoval from State Cheltenham Vet. Cem. 21. Signatule of Fujieral Service Lice 22. Name and Address of Facilia 1661 Good Hope										
			232 Parti. Enter the disease, shock, or heart failure. Li	or complications that o	caused the deat	th. Do not en	ter the mode of dy	ring, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Non	Isch	MIC	Carlio	my ophet	1,			9nset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		//				1
	Cxammer	L	Sequentially list conditions, if any, leading to immediate	b. 47	perte	nsem					-	
	ed sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to	√r as a consec	(derice oi).					-	
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):						
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	calE		d								
.89	death certificate t attending physical for use as the b	edic										
Box	h cert endin	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		∃Ectopic pregnan	cv		230	. Date of deli	
	es that the death igned by the atte be detached for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of c		Other (specify)				Month	Day Year
P.0	at the I by the stach	hy	9 Unknown	All M					00- Did			the sever of death?
Ś	res th ignec	by	Part II. Other significant condi	tions contributing to d	leath but not res	sulting in the t	inderlying cause g	given in Part I.		Yes 2 1		the cause of death?
oro	w require been signature	eted							- 11			
ec	e law has b	Completed							24a. Wa auto	s an apsy ormed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
al F	i: The								1 ☐ Yes	2 No	1 🗆 Yes	2 No
of Vital Record	Physician: this certific ral director,	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	C	ther	eath (Check only		70th (0	
	Phys r this aral di	۲. To	27. Manner of Death	28a. Date	of Injury	28b. Time o	of 28c. Inj	ury at	Home 5 ☐ Res 28d. Describe			ary)
lon	nding ith. :: Afte e fune	atior	1 Natural 5 Pend 2 Accident inves	ding (Mon stigation	nth, Day Year)	Injury		onk? ∐Yes 2∐No				
Division	Atter rr dea ector by the	ifica	3 ☐ Suicide 6 ☐ Cou	minor 200. Place	e of Injury - At h ling, etc. (Speci	ome, farm, st	reet, factory, office	Э		(Street and I	lumber or Ru	ral Route Number,
Ö	s after all Direct all Direct ad in by	Certification:	4 - Homeda	Build	ing, etc. (Opeci	·y/			Ony or 10			
	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certific (Check only 2 Medicone)	ying Physician: To the al Examiner: On the b and man	e best of my kno pasis of examina oner stated.	owledge, deal ation and/or in	h occurred at the evestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) ar , date and pl	nd manner as ace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title attenti	rier /	0	Cm =	29c. Lice	nse number		29d. Date s	signed (Month	n, Day, Year)
	0 42		As D.7 km	me MD/	range.	1111	DS	D328	_	July	14717	2005
•	di		30. The and address of person	on who completed cau-	se of deth (1)	m 23a) (Type	Print)			-	1	
	1,		James Elmore,	M.D. 1040)3 Hosp	ital Di	. Suite	103 Cli	nton. MD	2073	5	
	Sta		31. Date filed (Month, Day, Ye	ar) 32. F	Registrar's Sign	ature			,			
	Regist	rar	1111 0	2005		L A						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Reg. N. U () 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** July 16, 2005 21:48 Wilczek, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 Carroll County General Hospital Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1**X** M 2 □ F Dec. 1952 Maryland Director 218-60-4275 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and them 27 is marked other then "natural", or items 23a or 28e-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State 7 is marked other than "naturel", or items 23a or 28e-1 show treumatic event, the Modical Examiner must be publised at 1 ☐ Yes 2 Ā No Director Westminster Maryland Carrol1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 730 Charringworth Road Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2至 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seven-Eleven Stores Owner/Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Akers Betty Wilczek Teddy John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 730 Charrin worth Road, Westminster, MD 21158 Shirley R. Wilczek (Wife) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ☒ Other (Specify) Entombment permit. Page Department o importent; if eny injury or once. = 5 Loudon Park Cemetery 7/21/05 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home -2 3620 Wilkens Ave., Baltimore, MD 21229 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Box 68760. Due to (or as a consequence of): the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time ol death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Diab of ex 1 Yes 2 No 3 Probably 4 Unknown Mochid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Overity autopsy 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?

Yes 2 \(\sum \) No 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA dir 2 this 28b. Time of 28c. Injury at Work? 28a. Date ol Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Vithin 24 hours after To the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl July 17,2005 100051974 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manchester MD 2110 Herbert M. Henderson Jr. MN 2013 Marchester RJ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 6 2005

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	tate of Marylan	d / Depa <i>Cer</i>	rtment of H <i>tificate of l</i>	lealth and Death	i Mental H	ygiene Reg. No		24441
	Physici		1. Decedent's Name (First, Middle, Last) Rachel Phoebe Weave	er				2. Date of I Month July	Da	y Year 2005	3. Time of Death 10:00 PM
,	/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or			40	. County of Dea	
1			1544 Barrack Lane 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Glen Bu	rnie Under 24 H	rs. 8. Date of F	i	nne Aru	
	Funeral Director		215-12-1216		Yrs.	Months Days	Hours M	rs. 8. Date of to (Month, 1) 2/6/1	Day, Year) 918	C	thplace (State or Foreign ountry) MD
	aryland show	_	10a. State 10b. County		y, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma	ecto	MD Anne Aruno	iei	Gren	Burnie			10g Ci	tizen of What C	
	h with	J Dir	1514 Barrack Lane			2100	61		log. Of	USA	ountry?
36	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "naturel", or liems 23s or 28s-f show event, the Medical Examinal must be notified at	by Funeral Director	1 Never Married 2 Married	Nas Decedent Ever in U. Armed Forces? I ∐Yes 2 X No I Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or I erto Rican, etc.)	No-	14. Race - Am Black, Whi Specify:	
Ş	72 hou nature ical E	ted	15. Oecedent's Education (Specify only highest grade co	on .	16a. Deced	ent's Usual Occupa	ation	undring	16b. K	(ind of Business	s/Industry
Maryland 21215-0036	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of OO NOT use retired		vorking		Own Ho	me
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lan I	should be and Mentai marked o	To Be	Henry Fleece				Sad	ie Metz			
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Baitimore,	Pages ment of ant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	IVALITOTTI STATE		n Cemetei	1 - / /	26/2005	G1e	en Burn	ie, MD
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DIVISION	Attending r death. ector; After by the fune	catic	Accident investigation			M 1 🗆 '	Yes 2 □ No		(8)		
2	s after of All Direct	Certification:	4 Homicide determined	 Place of Injury - At he building, etc. (Specify) 	ome, Iarm, stre	et, factory, office		City or 7	own, State	na Number or H e)	lural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director; / completely filled in by the t	Medical (29a. Certifier (Check only one) Cartifying Physicia (Check only one)	n: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the tim	e, date an) and manner a d place, and du	s stated. e to the cause(s)
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,	1		30. Name and address of person who compl	ated cause of death (Ita-	23a) (Tuno 1	T) S	700	<u>t ! </u>	101	7	2007
	5		GAYATRI NU	MAGS	TDDA	30,	Ble	2 130	mi	21	ND 21063
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ERIC WILLIAMS 05-4969 dap

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici		1. Decedent's Name (First, Middle, Last) ERIC Vawahn Williams		2 Date of Death	23, 2005 8:20a M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) JOHN HOPKINS HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
7.50	, Funeral Director		5. Social Security Number 6. Sex 16 M 2 F 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreig
	ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	•	10d. Inside City Limits 1 🖫 Yes 2 🗆 No
	h with the	Funeral Director	10e. Street and Number 2808 Hanlem Aw	10f. Zip Code 2 1 2 16	10g.	Citizen of What Country?
920	urs after deal al', or items :	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, I' a Medicul Edair is at missal to a willing at apple.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	Sa. Decedent's Usual Dccupation (Give kind of work done during most of work life. DD NOT use retired)	ing 16b.	Kind of Business/Industry
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	1 and 2 sh Health and em 27 is m	-	Jamal Williams	9b. Mailing Address (Street and Number or Run 3418 Wond Lumin Au of Disposition (Name of	BAJO	ty or Town, State, Zip Code) LIZIL Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		- ceme	tery, crematory or other place) MMOUNT 22. Name and Address of Facility	,	AUTO, MS
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ion of	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Magner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how in	
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	5 1 € 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2	29b. Signature and title of certifier MOUPLE Methods M	29c. License number OCME	JUI	Date signed (Month, Day, Year) LY 24, 2005
1	& 60×		30. Name and address of person who completed cause of death (Item 23a YAM) N. LOREU 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	111 Penn Street	Baltimor	e, Maryland 21201
i i	Sta Registr		JUL 2 6 2005	Sparle		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** eleni 07 24 10 Am 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Brooklandville
If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Months Brightwood Center Baltimore 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Funeral Months 1 M 2 QF Yrs. Director PA 92 220-80-5433 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health end Mantal Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Rockfleet Rd. 21093 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker n/a Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank A. Rittler Lucinda M. Siple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Elaine H. Rittler/niece 408 Rockfleet Rd. #101, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 7/28/05 1) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Onation 5 ☐ Other (Specify) Grace United Meth. Ch. Cem. Hampstead, MD 21. Si fra ure of Funeral Service License 22. Name and Address of Facility repar a Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Bryan W. Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA 3 DAYS Examiner Due to (or es e consequence of) Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the deeth certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence on Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DI= MENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 768 2 1 No diractor, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 Ho After this a funerel di 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Maturel 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No deeth. within 24 hours after deeth To the Funerel Director: A complately filled in by tha f 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Lecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 1047945 WY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSTUR DAIVE TOWNER WM ZIZOY ALFEM WW 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 26 2005

DHMH 16 Rsv 6/95

Registrar

Decedent's Name (First, Motion, Late) AFRICK ARISH County Year AFRICK ARISH County Year ARISH Year ARISH County Year Year ARISH Year AR			1	For State	State of Marylan		artment of H			2000	21111
ARAD CAST TAY CAST TA								Joann	2. Date of Death	-	3. Time of Death
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July 25, 2005			<	M HANDE	1) Deput.	Y	018	46/	1	uly 25	2005
30. Name and address of person who completed cause of de-th (Item 3a) (Type, Print)		4									
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ian cal	Decedent's Name (First, Middle,		rginia Str	aughn And	lerson	2. Date of De Month	Day	Year 2005	3. Time of Death		
ner	4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death	h		County of Deati			
	4003 Nemo Road			Randalls				Balto			
	5. Social Security Number 214-50-7363 Usual Residence of Decedent	5. Sex 7. Age 1 ☐ M 2 🖾 F	(In yrs. last birthday)) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, De	th ay, Year) -193		hplace (State or Forei untry) Va		
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Funeral Director	Md Bal 10e. Street and Number	to	Randall	stown 10f. Zip Code			10a Citi	zen of What Co			
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nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H		pecify Yes or No		14. Race - Ame			
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۲	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ing Address (Street				r Town, State, Z	Zip Code)		
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	20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 Demoual from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Lo	cation - City or	Town, State		
	'4 Donation 5 Dother (Spe			n Forest	1	-2005	Owi	ngs Mil	ls, Md		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West										
	Hum Dete 4300 Wabash Avenue Balto, 11d 21215										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 2:57 p LEROY BRADFORD ALLEN July_ 23 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE HERITAGE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 22 1941 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 → M 2 □ F **Funeral** Days Hours Min. Country) MARYLAND Yrs. 64 215-62-0803 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location show 10a, State 10b. County Hygiene. other then "naturel", or Items 23a or 28e-f show ent. The Medical Examiract must be notified at 1 □ Yes 2√NNo **Funeral Director** BALTIMORE BALTIMORE MARYALND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 1435 GOODWOOD ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SELE LABORER 6th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should ba fill ment of Health and Mental H tant: If item 27 Is marked other ETHEL LEWIS HERBERT ALLEN traumetic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 7 Reaching Circle, Baltimore, Maryland 21221 Naomi Thornton/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND MOUNT CARMEL CEMETERY 07-30-05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signatus of Funeral Service License cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final 6MONTT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a consequence of): Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No detachad the 9 Unknown 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISORDE pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peed: ULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 1☐ Yes To the Hospitel o Atter ding Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 atural 5 Pending 2 🗆 No 1 Yes dea h. 2 Accident investigation after dear 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Signature and (Hemp23a) (Type-Print) O-A RITCHIE Registrar's Signature TIMORE, MARYLAND

State

Registrar

31. Date filed (Month, Day,

Year)

7 2005

				State of Maryla				-		-egible.	
			1 - For State Registrar	olate of maryle	•	tificate of I				2005	21.1.1.8
	Observated		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		ZACHARY			AGATST		JULY	25 ^{Day}		3:55 A ^M
	Examin	ér	4a. Facility Name (If not institution, give			4b. City, Town, or		h	1	County of Deat	h
	Funeral		5036 RUSHLIGHT PA 5. Social Security Number 6. Sec	7. Age (In y	rs. last birthday)	COLUMBI.	If Under 24 Hrs	8. Date of Birtl	1	OWARD 9. Birt	hplace (State or Foreign
	Director		213-76-8959 18	M 2 F	56 Yrs.	Months Days	Hours Min.	8. Date of Birth Day 02/08/	1949	Co	UKRAINE
	and w.		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho	tor	MD HOWARD	С	OLUMBIA						1 □Yes 2√ No
	or 288	Director	10e. Street and Number			10f. Zip Code			10g. Çitiz	en of What Co	untry?
	ath wi	rai	5036 RUSHLIGHT PA			21044				U.S.A.	
	ltems	Funerai	11. Marital Status 1 ☐ Never Married 2 → Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No	13. Y	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	specify Yes or No- to Rican, etc.)	1	4. Race - Ame Black, White	e, etc.
036	72 hours after death with the Maryland naturel', or Hems 23a or 28a-f show disal Examiliar must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2 <mark>Ž</mark> No	Specify:			Specify: WH	ITE
2-0	4 within 72 hours after death with the Marylan jiene. r than "naturel", or Items 23a or 28a-f show tha Madical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kir	d of Business/	Industry
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ylar	should be nd Mental markad o matic eve	ToE	ISAK		AGATSTE:		BEILA				KAPLAN
Maryland 21215-0036	d 2 shoth and 7 is muttraum		19a. Informant's Name/Relationship (Ty DIANA AGATSTEIN			ng Address (Street a RUSHLIGH					
	ges 1 and 2 should it of Health and Mer if item 27 is marks or other traumatic		20a. Method of Disposition			sition (Name of		Date 26/2005			
Baltimore,	Pages nent of I ant: If its ury or o		1 M Burial 2 ☐ Cremation 3 ☐ P 1 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State							
3alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	se Parl		Name and Addres					
	40260		23a. Part1. Enter the disease, or compl	ications that caused the de		900 REIST				VILLE,	Approximate
d	Pnysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	Δ4 .1	enter	,		, , , , , ,			Interval Between Onset and Death
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Records,	w requir s been si should	ompieted						24a. Was a	 an		topsy findings available
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lon	Attending r death. sctor: After by the funer	28a. Date of injury at 28b. Time of 28c. Injury at 28b. Time of 28c. Time of 28						200. 003010011	ow injury	occurred	
Division	f or Attendi after death. Director: A I in by the fu	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and n, State)	Number or Ru	ral Route Number,
Q	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Cer	29a. Certifier 1 Certifying Phys	pician: To the heat of mul	canuladae deeth			I and due to the			-total
	e Hos 124 hc e Fun letely (ledicai	(Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	ne, date and place pinion, death occi	e, and due to the d urred at the time, d	date and	and manner as place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date	signed (Month	n, Day, Year)
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h	1		30. Name and address of person who co	Λ .	tem 23a) (Type,	Print)	alle D.	يد. ا ه		· 11 -	MD 21093
	Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Redistrar's Sig	gnature /	Courts	4113 100	a. Lytt	Cerl	es llegge	10175 21073
b	Registr	ar	JUL 4 1	LUUS JUNEAU							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** George Bernard Arnold 24, July 2005 7:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9420 Whetstone Drive Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1⊠M 2□F 214-34-2516 Director 68 May 23, 1937 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Montgomery Village 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9420 Whetstone Drive 20886 Items 23a United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filad within 72 hours after ☐ Yes 2 Yes, Give 1 ☐ Never Married 2X Married 2 🔀 No Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filad wit Department of Health and Mental Hygiene Important: If item 27 Is marked other tha any injury or other traumatic event, If all once. Research Biochemist 5+ Gillette Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Charles Robert Arnold Mary Angela Dilley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Arnold / Wife 9420 Whetstone Drive, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of 20a. Method of Disposition Date 20c. Location - City or Town, State July 28, 2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, * 4 ☐ Donation 5 ☐ Other (Specify) Heaven Cemetery Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service L M00803 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon Cancer 2 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be axecuted burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ło in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 💢 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 V Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) D33686 July 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Miller, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832 31, Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Bleen & Specie

			1 - For State Registrar	State of	Marylar		artmen				lental H	ygien Reg. N	/	5	2445	0
	Dhysia	ion	1. Decedent's Name (First, Middle, La	st)							2. Date of D) Turk		3. Time of Dea	ath
	Physic /Medi		Clarence Joseph									25 ,	2005	ear	6:45P	М
	Exami	ner	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		4	c. County of	Death		
			Mariner Health					nesda		0.411	· · · · · · · · · · · · · · · · · · ·		Montgo			
	Funeral Director		5. Social Security Number 6. \$ 458-09-0722	ioX M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D Dec • 2	irth ay, Yea	() 15 3		lace (State or Fo.	reign
			Usual Residence of Decedent		03						Dec. 2	L , 1	915 1	Loui	siana	
	show		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Li	mits
	e Ma	cto	Maryland Montgom	ery	Ro	ckvil1	e								1 ☑ Yes 2 ☐]No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wha	at Coun	try?	2
	ath w	<u>a</u>	118 Monroe Street					0850					ted St	ate	s	
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	I.S. 13. \	Nas Deced f Yes, spec	ent of His	spanic Ori	gin? (Spo), Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Black,			
36	rs aft		1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Date		-69	I ☐ Yes 2	2 🔯 No	Specify:				Specify:	Whi	te	
Ö	within 72 hours after death with the Maryland one. than "natural", or itams 23a or 28a-f show the Medical Exertine transt be ricitlified at	Completed by	15. Decedent's E	ducation		16a. Deced	lent's Usua	I Occupa	tion			16h	Kind of Busin	oes/lna	luotar	
215	Medi	ple	(Specify only highest gra	completed) College (1-4)	or 54)	(Give	kind of wor DO NOT us	k done d e retired)	uring most	t of work	ing	100.	Tring of Busin	1033/1110	ustry	
21	be filled withir ital Hygiene. Ital dother than event, the Me	E O	Eloniomary, Secondary (6 12)	4		Mar	nager					Sp	orts H	aci	lity	
ng	be filed tal Hygid d other event,	Be	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle					
<u>yla</u>	2 should be and Mental I is marked or aumatic eve	ပ္	Aubrey Paul Adam								laire G					
Maryland 21215-0036	s 1 and 2 should if Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (al Route Numb					
a î	ss 1 and 2 of Health of itam 27 I		Sarah P. Adams/Wi	fe	20h 5	118 Me	onroe	Str	eet,						and 2085	0
Baltimore,	ages of of J		1 Burial 2 □ Cremation 3 □		ite Zoo. F	emetery, cran	ington	her place N)	0cto		20c. l	_ocation - Cit	y or To	wn, State	
틆	iit. Partmer artmer ortant njury		* 4 □ Donation 5 □ Other (Specifical Septime Licent		Na	tional	Cemet	ery		7, 2	005	Ar1	ington	, V	irginia	
Ba	permit. Pages Department of Minportant: If its any injury or of ODCE.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Fun 300 West Montgomery Av 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res							uneral Avenue	Hote, Ro	ne/Roc ockvil	kvi le,	Lle, Inc MD 2085	Ō		
	Priyaician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caus one cause on each	ı iine.	h. Do not ente Lateral						arrest,			Approximate Interval Between Onset and Death To Weeks	1
	/Medical		resulting in death)	Due to (or	as a conseq				.011 1	ii o ain	Onita			1 1	O WEEKS	
	Examiner		Sequentially list conditions.	b		sphagia									Years	
	pe jis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):										
	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to /or	as a conseq	uence of/:										
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687	ficate physis the	edicai		d										+		
Вох	death certific e attending p od tor use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	incy							23d. Date of	dalisas		
m	death e atte d tor	icia	in the past 12 months?	1□Live birth 4□Pregnant	at time of d		Ectopic pre Other (spe						Month		y Day Year	
o.	that the de led by the a detached t	hys	9 Unknown	9□ Unknown												
G,	requires that the een signed by th hould be detache	Completed by Physician/Med	Part II. Other significant conditions of		but not resi	ulting in the un	derlying ca	use giver	in Part I.		23e. Did 1	tobacco	use contribut	e to the	cause of death?	,
D.C	w require been si should I	pa	Atrial Fibrill	ation							10	Yes 2	⊠ No 3□] Proba	bly 4 □Unkno	/wn
Records,	2 00	pie	Dementia								24a. Was		24b. Were	autop	sy findings availa	ıble
<u> </u>	Attanding Physician: The law or death. sactor: Atter this certificate has but the funeral director, page 2 si	Con									auto perfo	rmed?	deat	to com h? Yes 2	pletion of cause	ΣĬ
/ita	cian: ertitic ector,	Be	25. Was case referred to medical examiner?								(Check only o	one)				
Division of Vital	Attanding Physician: r death. actor: Atter this certition by the funeral director,	2	1 ☐ Yes 2 ★No			ER/Outpatient		Other	4 ⊠ Nur	sing Hon	ne 5 🗆 Resi	dence	6 Other (S	Specify)		
2	Atter Atter funer	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, L	jury Day Year)	28b. Time of Injury		c. Injury a Work?	at	2	8d. Describe	how inju	ry occurred			
2	or Attancafter death	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		nium. AAba		M		s 2⊡N		0/ 1					
	ē ģ ∰ ⊆	Certification;	4 Homicide determined	28e. Place of I building,	etc. (Specify	ne, rann, stre	et, ractory,	οπισθ		2	City or To	Street ar wn, State	nd Number oi e)	Hural i	Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in the formulation of the form	dicai C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	iller: On the basis	of examinat	wledge, death ion and/or inve	occurred at	t the time	, date and	place, a	nd due to the	cause(s) and manner	r as stat	ted.	
	vithin 2 To the complet	Med	29b. Signature and title of certifier	and manner	stated.			License r					te signed (M			
	- ≱ ⊢ 8		_	mar	m.D			D365.					Ly 26,			
0	11/2	1	30. Name and address of person who d			222) /7:				_		Ju.	-y 20,	200	, ,	
	1//		Pankaj Talwar, M.			monsto		ve.	#401.	Roc	kville	. M:	arvlan	d 20)852	
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	Registra	ar	JUL 2 7 2	.UU5	Ever.	The Man	and in									

			1_ State	Department of Health and Mental H Certificate of Death	2005 2005
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
	Physici /Medio		Samuel Irmstron	9 Jr. 07	23 05 1815 M
4	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Euperal		MCI - Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date of 8	Birth 9. Birthplace (State or Foreign
в	Funeral Director		219-78-6470 1XM 20F 46	Yrs. Months Days Hours Min. (Month, I	Day, Year OF O Country)
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tou	vn or Location	10d. Inside City Limits
	ith the Marylan or 28a-1 show on notified at	tor	Maryland N/A Ba	ilti more	1 ☐ Yes 2 ☐ No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	a 23a		1805 N. Carey ST.	2/2//	No- 14. Race - American Indian,
(0	ritem ritem	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2 No	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
5-0036	72 hours after death with the Maryland natural', or itema 23a or 28a-f show dical Evantinet must be rodiffed at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
15-	n 72 h i "natu ledica	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired)	16b. Kind of Business/Industry
2121	filed within 7 Hygiene. other than "r ant, the Med	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Unemployed	NA
	be filed tal Hygid d other evant, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	de, Maiden Sumame)
Maryland	should be nd Mental marked o	ဥ	19a. Informant's Name/Relationship (Type, Print) Brother 19	b. Mailing Address (Street and Number or Rural Route Num	lûe Lee ber, City or Town, State, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hyglene. Itam 27 is marked other than "natural", or itema 23a or 28a-1 show itam 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic evant, I'm Medical Evantinatinatic beneditied at		Mr. Gregory Armstrong 5	208 Loch Raven Bly	1d. to Batto, Md. 21239
ore,	ges 1 a it of He if itam or othe		20a. Method of Disposition 20b. Place cemete 1 ABurial 2 Cremation 3 Removal from State	of Disposition (Name of party, crematory or other place)	20c. Location - City or Town, State
Baltimore,	Par train		*4 □Donation 5 □Other (Specify) 21. Signaftye of Funeral Service Ucensee	22. Name and Address of Facility	Dundalk, IVId.
Bal	permit. Departrimports any inju		Deserby L. Russ	Joseph L. Ryss Funer	al Home, P.A.
			23a. Part / Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	10 Squamous Cell G	A of bladder
9	Examiner			or).	
-	sit 9d	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	JI).	
_	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):	
1760	# × #		d		
x 68	leath certifica attending ph d for use as th	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		
Вох	leath o	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
P.O.	that the de ed by the detached	hysl	9 Unknown		
	w requires that s been signed t should be det	þ	Part II. Other significant conditions contributing to death but not resulting	, , , , , , , , , , , , , , , , , , , ,	I tobacco use contribute to the cause of death? Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Vunknown} \)
örc	been s	eted	14 Tangarlancia	24a. Wa	
of Vital Records,	he law e has age 2 s	Completed	H Office Terristors	aut	opsy prior to completion of cause of death?
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of V	Physician: r this certifica ral director, p	ပ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	·	sidence 6 XOther (Specify)
on	Attanding For death. actor: After by the funer	tlon		Injury Work? M 1 Yes 2 No	TIOW INJURY OCCURRED
Division	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	To the Hospital or Att within 24 hours after d To the Funaral Diract completely filled in by		29a. Certifier (Check only Check only 2 Medical Examiner: On the basis of examination at	e, death occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	thin 24 thin 24 tha F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F 3 F 8		mp	D57537	7/23/05
1-	1/		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	
l			1860 Kuxbury CD , H 31. Date filed (Month, Day, Year)	agerstown MD 217	746
	Sta Registr		JUL 2 7 2005	13. South	

State of Maryland / Department of Health and Mental Hygienes For State Registra 24452 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 Elizabeth Acklin July 18, 3:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ivy Manor Assisted Living Ellicott City Howard 8. Date of Birth (Month, Day, Year) June 21, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 95 167-42-5535 Director 1910 Pennsylvania Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral', or Itams 23a or 28a-f shov Examiner must be notified at 1. Yes 2 No Director MD Howard Columbia the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5580 Vantage Point Road #7 21044 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after □Yes 2□No Yes. Give X 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Wo Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Year or Dates "natural", Completed ar than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home th and Mental Hygie 27 Is marked othar traumatic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John M. Skelton Annie Scanlon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Klein (Daughter) 5580 Vantage Point Road #7 Columbia, MD 21044 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 4 ☐ Donation 5 ☐ Other (Specify) Jefferson Memorial Park 7-22-05 Pittsburgh, PA 22. Name and Address of Facility
Jefferson Memorial Funeral Home permit. 21. Signatury of Funeral Service Lic - see au 301 Curry Hollow Rd. Pittsburgh, PA 15236 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Cerebrovascular Accident 1 Week /Medical Due to (or as a consequence of): Examiner Sepsis l week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Cardiovascular Disease vears Due to (or as a consequence of): Box 68760, Dementia Physician/Medicai years IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐XNo ō Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 X No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ DOther (Specify)Asst Living P 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31172 July 19, 2005 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Harry Oken, M.D. 10700 Charter Dr., Columbia, MD 31. Date filed (Month, Day, Year) 32. Register's Signature State 7 2005 Registrar More A. parke

			For	State of Mary				lental Hyg	iene	
			1 - State Registrar		Cer	tificate of	Death	2. Date of Deat	9. No 2005	24453
	Physici	an	1. Decedent's Name (First, Middle, Last)			1.		Month July	Day Year 23, 2005	6:45A. ^M
	/Medic Examin	_	Joseph 4a. Facility Name (If not institution, give s		ugustyn		r Location of Death	July	4c. County of Dea	
1	LAdiiii	CI	935 Oldham Stre			Balti	imore		n/a	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
ŀ	Director		212-42-3511 Superior December 1	6	1 Yrs.			Dec13,	1943 Mar	yland
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Man B-f sh	tor	Md. n/a		Ва	1timore	9			1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	_ *
	ath w	rai	935 Oldham Stre		5-11-C 40-1	2122		anife Van an Na	USA 14. Race - Ame	
	items items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No 	in U.S. 13. V	Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whi	
920	72 hours after death with the Manylan natural', or items 23s or 28a-f show dical Exeminer must be notilled at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•	I□Yes 2∏ No	Specify:		Specify: W	nite
5-0	72 hours after death with the Maryland 'natural', or items 23s or 28s-1 show dies! Exeminer must be notilited at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	lent's Usual Occup	during most of work	ing	16b. Kind of Business	/Industry
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2	filed v Hygie other t		11th 17. Father's Name (First, Middle, Last)		Co	nstruct	10 n 18. Mother's Name	e (First, Middle, A	Constru Maiden Sumame)	ICT10n
lan	S a b ≥	To Be	Edward Augustyn	iak			Genev	ieve H	Korowski	
Maryland 21215-0036	d 2 should th and Mer 7 is marke treumatic	-	19a. Informant's Name/Relationship (Type	oe, Print)					City or Town, State,	
	s 1 and 2 f Health item 27 i		Geraldine Augus					_		
Baltimore,	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Ob. Place of Dispo- cemetery, cren		'		20c. Location - City or	
Him	그 문원들 .		* 4 □ Donation 5 □ Other (Specify)		Holy Ro				Baltimore	
Ba	perm Depe Impo sny i	*4 Donation 5 Other (Specify) Holy Rosary Cem 7/26/2005 22. Name and Address of Facility Kaczorow 1201 Dundalk Ave. Bal								
	4.		23a. Part1. Enter the disease, or comblishock, or heart failure. List on you	cations that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- 611	1 ER	ta wa	2E			Sinset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):		CARCI	1 DAAD		1.5 4510
į.	Examine:	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co		COCHIC	CHU	1001017		one your
П	uted I Insit	Examiner	Cause (Disease or injury							
o,	te be executed ysicien and te burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or as a co	nsequence of);					
3760,	9 % 6	lical	€ d							
x 68	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pr	regnancy				23d. Date of de	liven
Вох	eath c	cian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify) _	Υ		Month Month	Day Year
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S, D	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions con		ot resulting in the ur	nderlying cause giv	ren in Part I.		acco use contribute to	>
ord	v require been sl		UVER CIL	100/		···········		1Ye	s 2 No 3 P	obabiy Dunknown
Record	e law r has bo	Completed	the cutous	51 070	100			24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of
al R			attoric of	ANCLOA	1177			1 ☐ Yes	No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatien	t 3 DOA Oth	26. Place of Deati		nce 6 □Other (Spe	cufv)
J O		H-	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injur		4.4	w injury occurred	
sior	Attending F death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(manning stay)	, ,,,,		Yes 2 No			
Division	tel or Attending s efter death. el Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
	urs e		29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, death	occurred at the til	me, date and place,	and due to the ca	use(s) and manner as	s stated.
	To the Hosp within 24 ho To the Fund completely f	edicai	(Check only 2 Medical Examination)	er: On the basis of exa and manner stated.	mination and/or inv	estigation, in my o	ppinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	S M		29c. Licens	y a 3 y	29	d. Date signed (Mont	
)	1		PICUUMIU	, ""/			•		July 25,	
1	1		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	FUL PI	L. BAU	m on	2120	_
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	de				
	Registi	ar	JUL 2 7 2005	of the state of	A 127					

do		artment of Health and Menta	
	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. 3. Time of Death
Physician		Mor	nth Day Year
/Medical	A. Carlle Name (March Carles)	4b. City, Town, or Location of Death	7 21, 2005 8:30 P. M
Examiner	9885 LYON AVENUE	LAUREL	HOWARD
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, Date	of Birth 9 Birthplace (State or Foreign
Director	220-32-6894 1⊠ M 2□ F 68 Yrs.	Months Days Hours Min. (Mor. NOV.	23, 1936 WEST VIRGINIA
9	Usual Residence of Decedent		
arylar ahow	10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
with the Marylam tor 28a-f ehow be notified at	MD HOWARD LAUREL		1 ☐ Yes 2X No
with the nor 2 Direct D	10e. Street and Number 9885 LYON AVENUE	10f. Zip Code	10g. Citizen of What Country?
tter death with tter death with riter must be instrmust be	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20723	USA
ltem	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (Specify Yes i Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- ttc.) 14. Race - American Indian, Black, White, etc.
D36 Jr. or DV		☐ Yes 2X☐ No Specify:	Specify: WHITE
2 hou callure	15. Decedent's Education 16a. Deced	ent's Usual Occupation	16b. Kind of Business/Industry
215 Prin 7	(Specify only highest grade completed) (Give life. L	kind of work done during most of working OO NDT use retired)	
21215-00 ad within 72 hou yejene. The medical it, the medical it, the medical Completed	8 Ø CARP	ENTER	WILLIAM L. BERRY CO.
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neture!, or Items 23a or 28a-1 ehow aumatic event, the Madical Experience must be notilized at To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, I	Middle, Maiden Sumame)
yla ould b Ment Ment Ment Ment Ment Ment Ment Ment	CHARLES BOSWORTH	ALDA BALYARD	
Aar 2 sh 2 sh 1 and 1 s m		g Address (Street and Number or Rural Route	
C, N 1 and 1 and 1 eeltl 1 eeltl 1 ther t	BARBARA VACCA / DAUGHTER 9885 20a. Method of Disposition 20b. Place of Disposition	LYON AVENUE, LAUREL, MARYLA	AND 20723 20c. Location - City or Town, State
Ages at 10 to 10 t	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	natory or other place) 7_26_05	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel; or item any injury or other traumatic event, the Medical Examinat once. To Be Completed by Fun	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22	REMATORY	LAUREL, MARYLAND
De mem Depart impo	The mifild forker	7601 SANDY SPRING ROAD, I	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac or respira	Interval Between
Physician	Immediate Cause (Final disease or condition	pulmonay Fibr	OSIS Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
nsit nine	Cause (Disease or injury		
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ox 687 certificate right physics as the			
Box 68 eath certific attending plot use as a cian/Mec	IFFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy	23d. Date of delivery
- 0 0 0 ·-	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
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	Part II. Other significant conditions contributing to death but not resulting in the un		Did tobacco use contribute to the cause of death?
ecord law requir sas been si	Λ.	1 thmasis	1 Yes 2 No 3 Probably 4 Unknown
I Records, P.O. The law requires that the page 2 should be delache Completed by Phys	Alcohol abose.	24a.	Was an autopsy findings available prior to completion of cause of
		10	performed? death? Yes 2 No 1 Yes 2 No
of Vital F Physicien: Th Physicien: Th ribis certificate ral director, pag	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check	1
of \ Physical Physica	1 Inpatient 2 En/Outpatient	3 BOA 4 INDISHING THE ST	Residence 6 Other (Specify)
on on ding the tune tune	27. Magner of Death Natural 5 Pending (Month, Day Year) Accident investigation Pending (Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No	and now injury coodings
Division to Attending after death of the transfer of the true birector: After the birector after the by the fune ertification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	et, factory, office 28f. Loca	tion (Street and Number or Rural Route Number,
Division of tel or Attending P is after death. a) Director: Alter ted in by the funers Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)
	29a. Certifier (Check only Check only (Check only Check on Che	occurred at the time, date and place, and due to	o the cause(s) and manner as stated.
the Hospi nin 24 hou the Funer apletely finer	and manner stated.		time, date and place, and due to the cause(s)
To the within To the common common MM	29b. Sign ature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
14	Alda MO	D58747	July 25, 2005
4	30. Name and address of person who completed cause of death (Item 23a) (Type, P		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	200 Columbi	a MN 31044
Registrar	31. Date filed (Month, Day, Year) JUL 2 7 2005 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1524 PM Priscilla 2005 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayveni Medul Contr Baltmare Johns Hopkins n/a 8. Date of Birth (Month, Day, Year) Tilly 29, 1930 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🖫 F 74 Pa. 212-34-0870 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Jaydee Ave. 842 21222 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White β 3 X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Factory 8 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irvin Miles Rager Edna Grace Irvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11347 Holter Rd. White Marsh Md. 21162 Manda Crawford daughter July 30 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY Hill 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2005 Middle River * 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiraton failure Two homs Due to (or as a consequence of). Dulmamay edena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a contence of). Cardio more Due to (or as a cons oue ce of). Cormany disare IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 Yes 2 No Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? with Road Ventorcular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 20 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death

Examiner certificate be executed burial-transit attending physicien Box 68760 Physician/Medicai for use as the P.0. been signed by the should be detached Division of Vital Records, þ Completed certificate has this a Hospital or Attending Pi 24 hours efter death. Funeral Director: After the Certification:

Physician

Examiner

/Medical

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or finanty injury or other trainment.

Baltimore, Maryland 21215-0036

with the Marylend

deeth v

28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Matural 2 Accident 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year) 2002

attern 30. Name and address of Person while completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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within 2 To the

2

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 7 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:30 PM NICOLE BUCHANAN JULY 24 2005 ROZZIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** GOOD SAMARITAN HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 35 Director MARYLAND 217-76-7218 OCT. 1969 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1)XYes 2 □ No Directo MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "natural", or Items 23a 2504 WOODBROOK AVENUE 21217 Funerai U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced al Hygiene. I other than "nature went, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade UNEMPLOYED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event once. Be David Buchanan Ashley Johnsie Riles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Delverne Rd., Baltimore, Maryland 21218 Ashley Nicholson/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 07-30-05 BALTIMORE, MARYLAND 21. Signatura I Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE And . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by SARCOMA 1 Yes 2 No 3 Probably 4 Unknown Completed PULMONARY EDEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check onl one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes WNo P 2 ER/Outpatient 3 DOA Sign 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide in 24 house the Funeral Directory 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tareas M.D. JULY, 24, 2005 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Coch Raven Blvd, Baltimore, MD 21239 ABOU-KHAMIS 32. Signature 31. Date filed (Month, Day, Year) State Registrar

Physician /Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For Unpersonal State Property State	end Item	23a, 27, 28	laryland a-f pe	/ Depa r me <i>Cei</i>	artment of 1 G845 7-28 rtificate of	lealth and 3-05, tas Death	Mental Hy	giene	Ωn		
*	Decedent's Name	(First, Middle, L	ast)					2. Date of De	aath	UU	3. Time of Derath	
an	DONELYN	M. BALANC	E					Month 1111 V 10	Day 2.005	Year	3:16 P M	
al er	4a. Facility Name (II	not institution, gi	ive street and number	r)		4b. City, Town, o	Location of Dea		,	ty of Deat		
•	30 Steve	ns Court				Gaithe:	rshuro		Mont	omer	v	
П	5. Social Security N	umber 6.	Sex 7. A	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	rth Vearl	9. Birl	thplace (State or Foreign	
	5. Social Security Number 6. Sex 1 M 2 F 65 Yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct 1987 Hours Min. 0 (Month Days) 9. 8 Date of Birth Oct 1987 Hours Min. 0 (Month Days)									WIS	CONSIN	
	Usual Residence of Decedent											
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lai	15840 MU	LLINIX ROA	(D			21797			USA			
ne	11. Marital Status		12. Was Deceden Armed Forces	nt Ever in U.S. s?		Was Decedent of H				ace - Ame ack, Whit	erican Indian,	
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ete	(Spec	15. Decedent's E ify only highest g			(Give	dent's Usuaf Occup kind of work done	during most of wo	orking	16b. Kind of	Business	Business/Industry	
Completed by Funeral Director	Elementary/Second	ndary (0-12)	College (1-4or	r 5+)		DO NOT use retired LOGISTI		I TECH	WAITER	PFF	D ARMY MED.C	
ပိ	17. Father's Name (First Middle Las			011121	2001011		me (First, Middle			D ARMIT MEDIC	
Be						and the second				ina)		
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	DAVID & SUZ						.,					
	20a. Method of Disp		IN / PRIENDS			O A.E. MULL osition (Name of	INIX ROAD,	Date	20c. Location			
	1 🗆 Burial 2 [☐Cremation 3	☐Removal from State	е сеп	netery, crer	matory or other place	·e)	54.0				
	4 Donation 5 Other (Specify) BALT/WASH CREMATORY LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNEDAL HOME LINC											
	21. Signature of Fu	Wiefelt	Jac Leur			7601 SANDY	- 1	LECK FUNER AD, LAUREL	RAL HOME, , MARYLA	INC. ND :	20707	
	23a. Part1. Enter th	ne disease, or con	nplications that cause y one cause on each	ed the death.	Do not ent	ter the mode of dyin	g, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between	
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an/A	IF FEMALE: 23b. Was decedent		23c. If yes, outcom 1 ☐ Live birth			⊒Ectopic pregnancy			23d. D	ate of del	livery	
Sicia	in the past 12 1 Tyes 2	months?	4☐Pregnant : 9☐ Unknown			Other (specify)			M	lonth	Day Year	
Completed by Physician/Me	9 Unknowh											
by	Part II. Other signifi	cant conditions	contributing to death	but not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	ntribute to	the cause of death?	
ed								10	Yes 2 □ No	3 🗌 Pr	obably 4 □Unknown	
pie								24a. Was		. Were au	utopsy findings available	
E								auto perfo	ormed?	death?	completion of cause of	
BeC	25. Was case refer	ed to medical					26. Place of De	ath (Check only o		100 TOS		
examiner? Comparison Compa									gity) at scene			
	27. Manner of Death		28a. Date of In	jury 2	8b. Time of	f 28c. Injun Worl			how injury occu		unk	
atio	1 ∐Natural 2 ☐ Accident	5 Pending investigate	Found: 7-10-05		briro'	at 10	Yes 2 X No					
Hic	3 Suicide 4 Homicide	6 X Could not determined	be 28e Place of fr			reet, factory, office		28f. Location (Street and Num	becor Ru	vens Court	
Cer			Found	it Resi	dence	9		Gaither				
Medical Certification:	29a. Certifier (Check only one)	1☐ Certifying P 2X Medical Exa	hysician: To the bes miner: On the basis and manners	of examination	edge, death n and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the	cause(s) and m	nanner as	stated.	
Me	29b. Signature and					29c. Licensi	number		29d. Date sign	ed (Mont	h, Day, Year)	
29b. Signature and title of certifier 29c. License number 0.C.M.E. 29d. Date signed (Month, D. July 11, 200												

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State

Division of Vital Records, P.O. Box 68760,

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

24Bjycciatt Fy 111 30. Name and address of person who will all the state of person who will all the state of person who will all the state of person who will all the state of person who will all the state of person who will all the state of person who will all the state of person who will all the state of person who will be a state of person who will be

Registrar

Physician /Medical Examiner the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physicien and Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Director

Completed by Funeral

Be

Examiner

Funeral

Director

item 27 is marked other then "neturel", or items 23s or 28e-f show other treumatic event, the Mardical Express must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then

any injury o

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

nerel Director: / / filled in by the f

certificate has

this

To the Hospitel within 24 hours a To the Funerel C

Physician/Medicai Examiner

by

Be Completed

Certification: To

edical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No 9 Unknown

> 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

1 Natural 2 Accident

3 🗍 Suicide

29a. Certifier

4 Thomicide

(Check only one)

29c. License number D35844 29d. Date signed (Month, Day, Year) 25 2005

MD

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown Roggen 5400 Old Court Road

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State

			1 - For State Registrar	State of Ma	aryland /		artment of F		Mental Hy	giene	2005	24459
			Registrar Decedent's Name (First, Middle, Li	ist)		Cer	uncate of	Deam	2. Date of De	Reg. No.	- 000	3. Time of Death
	Physici		Alice M. Bo	•					Month July 2	Day		
	/Medic Examin		4a. Facility Name (If not institution, gi	re street and number)			4b. City, Town, o	r Location of Deat			County of Deatl	6:15 P ^M
			2012 Somerset S	treet			Hyatt	sville		Pr	ince Ge	orge's
	Funeral				(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th		nplace (State or Foreign
į.	Director			1 M 2 TF 86	5	Yrs.			Sept 2	21, 1	.918 Was	hington DC
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
	Mary Fed	tor	Maryland Prince	George's	Hyat	tsvi	111e					1 □ Yes 2 🏋 🏋
	or 288	lrec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	23a c	alD	2012 Somerset St	reet			2078	32		Uni	ted Sta	tes
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Mactral Examination any injury or other traumatic evant, the Mactral Examination once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 XX If Yes, Give		"	Vas Decedent of H Yes, specify Cuba □ Yes 2 1 to	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Amer Black, White Specify:	, etc.
21215-0036	hour tural	q pa	3XXWidowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16		ent's Usual Occup	-41				White
15	n "na	plet	(Specify only highest gi	ade completed)		(Give	kind of work done	during most of wo	rking	IDD. KII	nd of Business/li	ndustry
212	d with giene r tha	mo	Elementary/Secondary (0-12)	College (1-4or 5-		dmis	sions			Hos	pital	
pu	al Hyg I otha vant,	BeC	17. Father's Name (First, Middle, Las					18. Mother's Nar	me (First, Middle,	Maiden :	Sumame)	
yla	Duld b Ment arkec aric e	Charles Naylor Jardin Carrie Dalzell										
Maryland	12 sh and rs m		19a. Informant's Name/Relationship Gary R. Boyd (S				g Address (Street:					
e,	1 and Healtl am 27 ther t		20a. Method of Disposition				Peach Dr				nd 2060. cation - City or T	
Baltimore,	ages int of t: If it		XXBurial 2 Cremation 3		I.		sition (Name of patory or other place	1	, 2005		-	Maryland
∄	artme artme ortan injur		*4 □ Donation 5 □ Other (Special Service Lice		TOPE		oln Ceme					6633 01d
B	permil Depar impos any ir		MADER		0153		Alexandi	ra Ferry	Road, C	lint	e, inc. on, Mar	vland 20735
	K ₂ .		shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cimpli	re M	18	81					Onsot and Death
6	Examiner			Due to (or as a	consequence	of):	1					lover
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to for as a								10951
	cuted	Examiner	that initiated events	· Huppi	MONOC	25	Elol Gr	COTA-				10451
ő	e exe ian a urial-t	Ex	resulting in death) Last	Due to (or as a	consequence	of):	7. +1					1
38760,	icate be executed physician and s the burial-transit	dlcal		d	KY JP	M	/t. F/	maci	Thor			3957
~		ω .	IF FEMALE:	23c If was outcome of	of pregnancy				-			
Вох	death certifice attending prod for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	12 months?						3d. Date of deliv Month	ery Day Year	
o.	0 0 0	hysl	1 ☐ Yes 2 ██¶o 9 ☐ Unknown	9□ Unknown								
ري ص	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	ontributing to death bu	t not resulting	in the un	derlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to t	he cause of death?
ş	w require been sig should b								1 🗆 Y	'es 2 🗓	No 3□Prol	bably 4 Dunknown
Records,	e law re has be	Completed							24a. Was a		24b. Were auto	opsy findings available empletion of cause of
	The page	Con							perfor	med? 2 No	death?	·
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Usanital.					th (Check only or	ne)		
of	shys this	£:	1 Yes 2 No 27. Many of Death		t 2 ER/O	utpatient Time of		4 Nursing H	ome 500 Viesid			fy)
on	After une	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injury Work	Yes 2 □ No	28d. Describe h	low injury	occurred	
Division of	il or Attanding after death. Director: After In by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injur	y - At home, fa	arm, stre			28f. Location (S	treet and	Number or Run	al Route Number,
ā	safter s after si Direct ad in by	Certification:	4 Homicide	building, etc.	(Specily)				City or Tow	n, State)		
	To the Hospital within 24 hours at To the Funeral Completely filled i	Medical ((Check only 2 Medical Exal	ysician: To the best of	examination ar	e, death id/or inve	occurred at the timestigation, in my or	e, date and place pinion, death occu	, and due to the c	ause(s) a	and manner as s place, and due to	tated.
	othe otha omple	Med	29b. Signature and title of certifier	and manner state	ed.		29c. License				signed (Month,	
)	->-0	/	· 477.	the 1		•	DIRE	りかる		71	26/6	
	W	1	30. Name and address of person who	completed cause of de	ath (Item 23a)	(Туре, Р	rint)			1-		9
7			Dr. Fiutowski, N	i.D. 601 Po	st Offi	ice l	Rd, #2A,	Waldorf,	MD 2060)1		
	Stat		31. Date filed (Month, Day, Year)	32. Redistrar	's Signature	4	porte					
	Registra	ır	JUL 27	LUUY JOHN	150 50	1			 			

			1 - For State Registrar		ryland / Dep		Health and M	lental Hygie	_	
		4	Decedent's Name (First, Middle, L.	ast)		Timouto or	Douin	2. Date of Death	. Ng. UU	3. Time of Death
i V	Physic /Medi		Rama Badamo					July 25,	2005 Yea	
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death	July 25,	4c. County of De	
			Montgomery Hosp	ce Casey Ho	use	Rockvi			Montgom	
	Funeral			Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Q.F	Birthplace (State or Foreign
	Director		218-96-6902	1□ M 2\\(\frac{1}{2}\)F	38 Yrs.	Months Days	Hours Min.	Nov. 16,	1966 Ir	ndia
	pug A		Usual Residence of Decedent 10a. State 10b. County	T	10c. City, Town or Lo					
	faryl	ō								10d. Inside City Limits
	28a-	Director	Maryland Montgom	ery	Rockville	1				1 X Yes 2 □ No
	with se or	ā		4-		10f. Zip Code			. Citizen of What	
	ns 23	Funerai	101 Nelson Stree	12. Was Decedent Ev	ver in II S 12	20850	Higgs of the Color		nited St	
' O	r Iter	FE	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, WI	nerican Indian, nite, etc.
ဗ္ဗ	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	sian Indian
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show a Mudical Eventirar marke riviliad at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation	161	b. Kind of Busines	
2	thin an	nple	(Specify only highest gas Elementary/Secondary (0-12)		life.	KING OF WORK done DO NOT use retire	during most of workind)	ng		•
7	ygier ygier yer th	Ş		College (1-4or 5+) 5+	Hi	storian			Federal (Government
밀	tal H d oth	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle, Mai	den Sumame)	
<u>×</u>	Men Men Marka arka	2	Nathan C. Ramak				Vanaja	Kuram		
Jai	2 sh and is m	3	19a. Informant's Name/Relationship				and Number or Rura			, Zip Code)
e î	is 1 and 2 of Health a item 27 is other treu		Michael Badamo/H	usband	101	Nelson St	treet, Roc			20850
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic event, it a Mudical Exactinative Irrantial and once.		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 [☐Removal from State	St. Igna	sition (Name of natory or other pla	July	29, 20d	. Location - City of	or Town, State
븙	t. Pa tmen tent: ijury		*4 □Donation 5 □ Other (Speci	fy)	Point	Cemeter	2005	Po	ort Tobac	cco, Maryland
Bal	permit Depar Impor any ir		21. Signature a funeral Service Line		Ro	Name and Addre	ss of Facility RO5	ert A. Pu West Mor	imphrey I	Funeral Home/ Avenue
	402.00		- Just		00803 R	ockville,	Maryland	20850-2	2805	Avenue
Ш			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	e death. Do not ent	er the mode of dyir	ng, such as cardiac o	respiratory arrest,		Approximate Interval Between
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Breas	t Cancer-	Metastat	ic			Onset and Death Months
	Examiner		1	Due to (or as a o	consequence of):					
E		L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a c	consequences of					
	nsit	nin	Cause (Disease or injury	200 10 (01 23 2 0	onsequence or,					
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
8760,	rate be executed physician and the burial-transit	dicai I	· ·							
89	ils d	Ø ·		, d						
Box	eath certifica attending ph	Physician/M	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	divery
m	death e atte	icia	in the past 12 months?	1 ☐ Live birth 2 (4 ☐ Pregnant at tirr		Ectopic pregnancy Other (specify)	<u>'</u>		Month	Day Year
J O	it the by th tache	hys	9 🗆 Unknown	9□ Unknown						
	iaw requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions	ontributing to death but r	not resulting in the un	derlying cause giv	en in Part I.	23e. Did tobaco	o use contribute	to the cause of death?
2	w require been sig							1 🗆 Yes	2 ∑ No 3□P	robably 4 Unknown
ပ္က	aw re 1s be 2 sho	plet						24a. Was an	24b. Were a	utopsy findings available
Vital Records,	sicien: The faw certificate has t irector, page 2 s	Completed						autopsy performed	? prior to death?	completion of cause of
<u> </u>	certifica rector, I	Bec	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 Ye	s 2 No
>	Q 5. <	To	examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Oth			6 V Other (Spe	ecify) Hospice
	nng Ph h. After th funeral		27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		28c. Injun Worl	/ at 28	3d. Describe how in	jury occurred	1105pice
UNISION	Attending ir death. ector: After by the fune	atic	2 Accident investigation	1	July Injury		Yes 2 □ No			
Ë	irect irect	ertification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre	et, factory, office	28	Bf. Location (Street City or Town, St.	and Number or R	ural Route Number,
ָ ב	ref D	O							,	
	Fune	edicai	29a. Certifier 1 ← Certifying Ph (Check only 2 ← Medicel Exer	ysicien: To the best of miner: On the basis of ex	arrimation and/or invi	occurred at the time	ne, date and place, ar	d due to the cause	(s) and manner a	s stated.
;	lo the hospitel of Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		one) 29b. Signature and title of certifier	and manner stated	l.					
,	≥ ≥ ≥ 8		255. Signature and title of certifier			29c. License	a number	29d. [Date signed (Moni	th, Day, Year)
1			whe you	ye -		D424	52	Jı	uly 25,	2005
4	~		30. Name and address of pe so who							
	Char		Chitra Rajagopal,		Muncaste	r Mill R	oad, Rockv	ille, Ma	ryland :	20855
	Stat Registra	ır	JUL 2	7 2005 Registr	West St.	Marie				

			1 - For State Registrar	State of Maryla	nd / Depa	artme		ealth and	•		е	5 21.	1 (1
			1. Decedent's Name (First, Middle, Last) 2. Date of Death						eath		3. Time	of Death	
н	Physic		Ann R. Peters						Month 07	25	Ye Ye	ar 5	ODAM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. Cit	v. Town, or	Location of Deat		- 1	. County of D		
4	Examii	ner	Collingswood Nurs				ckvil				ontgom		
	Funeral		5. Social Security Number 6. Se		last birthday)	If Und	er 1 Year	If Under 24 Hrs	8. Date of B		_	Birthplace (State Country)	e or Foreign
	Director		062-20-1507 1 Usual Residence of Decedent	□ M 2XF 85	Yrs.	Month	Days	Hours Min	8. Date of B (Month, D June 2	, 19:	20 A	Labama	
	/land	ŀ	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside	City Limits
	Man	to	Maryland Montgome	rv G	ermanto	งพา						1 □ Ye	es 2∑No
	r 28e	irec	10e. Street and Number				ip Code			10g. Ci	tizen of What	Country?	
	72 hours after death with the Maryland netural", or Items 23a or 28e-1 show licel Exartiner must be notified at	Funeral Director	12020 Amber Ridge	Circle #304		20	876			Un:	nited States		
	ms 2	Jer	11. Marital Status				edent of Hi	spanic Origin? (S n, Mexican, Puer	Specify Yes or N	lo-		merican Indian,	
9	after or Ite	Fū	1 Never Married 2 Married	1 ☐ Yes 2 📉 No					to Rican, etc.)			Vhite, etc.	
8	ours a	by	3 ☐ Widowed 4 ▼ Divorced	If Yes, Give 1 Year or Dates:		1 ☐ Yes 2 X No Specify:				Specify:	DIACK		
9	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Us	ual Occupa	ation luring most of wo	rkina	16b. F	(ind of Busine	ess/Industry	
2	within and the series of the s	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	·······g				
21215-0036	d wil	Completed		4	Teach	er				Pub:	Lic Scl	nools	
þ	e file al Hy loth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	e, Maidei	n Surname)		
<u>a</u>	Aentz Aentz rked rice	10 6	Jerry Peterson Nancy Ken						Kenel	orew			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23e or 28e-1 show any injury or other treumatic event, Ite Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Addre	ss (Street a	and Number or R	ural Route Numi	ber, City	or Town, Stat	e, Zip Code)	
Ž	alth alth 27 is		Joy Y. Piegre/Dau	ghter	12020) Amb	er Ri	dge Cir	cle #304	4, Ge	ermanto	own, MD	20876
ē,	s 1 a of He		20a. Method of Disposition		Place of Dispo	sition (N	ame of other place	9)	Date	20c. L	ocation - City	or Town, State	
9	Page ent o nt: If ry or		14☐ Burial 2/☐ Cremation 3 ☐ 14☐ Donation S ☐ Other (Specify	Hemipvai irom State	ndale 0	-			- 1 200	15 7	Cualcos	ee, Alab	
≡	nit. I		21. Signature of Funeral Service Licen	1131	22	Name	and Addres	s of Facility			- 3		
ã	permi Depa Impo eny ii		1 / O V 7.	M008	77 Ro	bert	A. F	umphrey ntgomer	Funeral	L Hon	ne/Rock	cville,	Inc.
			23a. P. 11. Enter the disease, or composhock, or heart failure. List only								CKVIII	Approxim	ate
	25-71	ļ.	shock, or heart failure. List only of Immediate Cause (Final									Onset and	
	Physician /Medical		disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of):										
	Examiner				quence or):								
		<u>~</u>	Sequentially list conditions,	b. Pneumonia Due to (or as a consec	luence of):							-	
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(,								
	le be executed ysician and e burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):								
760,	be e ician burià	cai E											
687	phys the		•	d									
×	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy							22d Date of delivery		
Вох	atten for u	jan	in the past 12 months?	1 Live birth 2 Fet:	aldeath 3	Ectopic Other	pregnancy		23d. Date of deli Month		Day	Year	
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	104(1) 3[) Other (specify)						
P.O.	that the death ned by the atter detached for u	P	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying	cause nive	n in Part I	23e. Did	tobacco	use contribute	e to the cause of	f death?
Records,	signed I	Completed by					accord give				_	Probably 4	
or C	w requir been si should I	ted	Atrial Fibrilla	clon					-		X		
ec	law asb	ple	Hypertension						24a. Was	DDSV	prior	autopsy finding to completion of	s available cause of
m m	The ate h page	no.	Diabetes Mellit	1S					pert 1 ☐ Yes	ormed? 24 No	death		
ita	sicien: The law certificate has b irector, page 2 sl	Be (25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)			
Į (Physicien: r this certific ral director,	Tof	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3□ [Othe Othe	A Nursing H	lome 5 ☐ Res	idence	6 □Other (S	Specify)	
0	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Describe				
Ö	death. ctor: Af the fur	atlo	2 ☐ Accident investigation			M		res 2 ☐ No					
Division of Vital	Atte ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, facto	ory, office		28f. Location City or To			Rural Route Nu	mber,
	el or s afte	Sert	T D T TO MINIO	Ballaling, Stc. (Speci	97				0.1, 0.1	, Oldic	-7		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	cal (29a. Certifier to Certifying Phy (Check only 2 Medical Exem	vsician: To the best of my kniner: On the basis of examina	owledge, deatl	occurre	d at the tim	e, date and place	s, and due to the	cause(s) and manner	as stated.	n(s)
	the Prin 24	Medical	one)	and manner stated.									
	To To Con	2	29b. Signature and title of certifier			2	9c. License				,	onth, Day, Year)	
•	,		Maria				DOD	61959		0	7/25/)5	
1	1		30. Name and address of person who o	completed cause of death (Ite	п 23а) (Туре,	Print)							
1	1		Aman Sibal, M.D.	, 1299 Lambert	on Dri	ve,	Silve	r Spring	, Maryl	and	20902		
	Sta		31. Date filed (Month, Day, Year) 7	2005 Registrar's Sign	ature 14	Ana	d. 1						
	Registr	rar	40L N 1	LUUU KATALE		41743	The same of the sa						

			For	State of Maryland	•		Mental Hygie	ne	
			1 - State Registrar		Certifica	te of Death	Reg.	No.2005	24452
П	Physici	an	1. Decedent's Name (First, Middle, Last)	0	V (and the same of th	Day Year	- 11'22
	/Medic Examin		4a. Facility Name (If not institution, give s			y, Town, or Location of Deat	h	4c. County of Death	
	LAGIIII	CI	229 N. Mou	T 0+11	2 1	Baltimor	e	NIA	7
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	Month	er 1 Year If Under 24 Hrs s Days Hours Min.		9. Birth	pplace (State or Foreign
	Director		Usual Residence of Decedent	65	Yrs.		May 3,1	940 1410	iryland
	fand ow		10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
	Mary P-f sh	tor	Maryland N/A	t F	Baltim	ore			1 XYes 2 □ No
	or 28	Jirec	10e. Street and Number	1 ai Apti	10f. 2	Cip Code	10g.	Citizen of What Cou	untry?
	ath w	rai	224 N. NOW	1T ST. 102	2 .	2/223		US	H
	items items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.! Armed Forces? 1 Yes 2 No	S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
336	urs aft	by	3 Widowed 4 Drivorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: 2	ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Exactirat mast be indiffed at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's Us	ual Occupation work done during most of wo	rking 16b	. Kind of Business/l	ndustry
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	filed v Hygie other t	CO	17. Father's Name (First, Middle, Last)	<u> </u>	Lanion	Tepresen 18. Mother's Nai	me (First, Middle, Maid	DEATA(E)	S union
and	d be i	To Be	Albert Nols	on Grac	0	Fmil	W Br	nok s	
Maryland	should I and Meni s marker umatic	-	19a. Informant's Name/Relationship (Ty)			ss (Street and Number or Ri	ural Route Number, Cit	ty or Town, State, Z.	ip Code)
	and 2 ealth a n 27 is		Ms. Kosalind 1	ope	425 T	hornfield	Rd. Bu	Ito, Md	21229
ore	Pages 1 nent of He int: if iter iry or oth		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ R		lace of Disposition (Nemetery, crematory or	ame of other place)	Pate 20c	. Location - City or T	Town, State
Baltimore,			'4 Donation 5 Dother (Specify)	60	arrison	Forest 93	12005 0	vings N	lills, Ma.
Ba	permit. Departr Importa any inju		21. Signatule of Funeral Service License	I RUN	1/ Josep	h, L, RUSS	Funeral	Home P	A.
			23a. Part / Enter the disease, or compli	cations that caused the death	n. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,	Ma 21211	Approximate
	Physician		shock or heart fallure. List only on Immediate Cause (Final	1	AL CA	UCER MET	ASTATIC		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		TO R MC	713111110		TWO MONTHS
L	Examiner	_	Sequentially list conditions, b				<u></u>		
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):				
	al-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):				
8760,	ficate be executed physician and is the burial-transit	dicai	€ d						
9	ng phi	Medi	IF FEMALE:						
Вох	eath certific attending p I for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal	death 3 Ectopic			23d. Date of deliv Month	veгу Day Year
0	the the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 Other (specify)			
۵.	res that the igned by be detact	by Ph	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
rds	w requires been sign should be	ed b					1 ☐ Yes	2 □ No 3 N Pro	bably 4 Dunknown
900	ie law requ has been je 2 shouli	piet					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
œ =	The page	Completed					performed 1 ☐ Yes 2 🔀	? death?	25No
Vita	Physicien: r this certific ral director.	Be	25. Was case referred to medical examiner?	ospital:		Othor	ath (Check only one)		
of	Phys r this ral dii	1: To	1 ☐ Yes 2 No '' 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 0 28b. Time of	OOA Other: 4 Nursing H	lome 5 Residence 28d. Describe how in		fy)
on	th. : Afte	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	of or Attendi after death Director: A d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, facto	ory, office	28f. Location (Street City or Town, Str	and Number or Rur	al Route Number,
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	Hosp 24 hou Funa etely fi	Medicai	29a. Certifier 1 N Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	ion and/or investigation	n, in my opinion, death occu	irred at the time, date a	and place, and due t	o the cause(s)
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	V , 0	2	9c. Li <i>ce</i> nse number	29d, [Date signed (Month,	Day, Year)
)			frederik S	itch M)		DSOSOD THEFT BALTI	Ju	LY 26.	2005
1	11		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Print)		14.4		
7)		31. Date filed (Month, Day, Year)	10 NONH (CINETATE A	THEET BALTI	MORE PLAT	MULTUD 2	1201
	Sta Registr		JUL 2 7	2005	As Ages	- Walter			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Charles Ju₁y 24, 2005 9:20 P Buffalano, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5900 Westchester Park Drive College Park Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1⊠M 2□F 28, 91 1913 New York Director 065-10-5102 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director College Park Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20740 United States 5900 Westchester Park Drive s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 42 - 46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Controls Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Buffalano Angelina Trapolina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5900 Westchester Park Drive College Park, MD 20740 Stella Buffalano/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent; if ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State Holy Rood Cemetery Jul 29, 2005 Westbury, NY ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas F. Dalton Funeral Home 21. Signature of Funeral Service License 23a. Part1. Enter the dise shock, or heart failur 29 Atlantic Ave., Floral Park, NY 11001 Approximate Interval Between Onset and Death 2 06 4 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fine osel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 🗌 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No 5 XResidence 6 Other (Specify) P Pis funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred • Hospital or Attending PI 24 hours after death. • Funerel Director: After the Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 055075 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fourzen m. D. 7525 Greenway auto Dr. T-3 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 7 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State AMEND ITEM #1 PER PHY G845 7/22/05/cate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Scus THOMISENA C. CARTER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA ptra OKENS Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** 1 □ M 2 1 F Months Min. Davs Hours 251-58-2561 80 S.C. Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show If a Medical Expedient ment be notified at 14 Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Tivoly Avenue USA 21218 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Crossing Guard 12th grade Baltimore City permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lula Robert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhynie Carter Son 8302 Tinsley Rd., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Loudon Park Cem. 7-28-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. hum 23a. Part1. Enter the disease, or complications that acused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Cerebrovascular accident days /Medical Due to (or as a consequence of): **Examiner** fibr: 11ation atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Due to (or as a consequence of): Examine The law requires that the death certificate be executed preast tran Cancer years and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28b. Time of 27. Manner of De th 28c. Injury at Work? Certification: 28d. Describe how injury occurred Japitat C.
4 hours after dea...
rat Director: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funeral (ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 20 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Michael Levy, MD, PhD July 21,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Pathology Soq, Baltimore, Maryland 21287 Michael Levy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 7 2005 Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)			tinoate or i	Jean	2. Date of Death	1. N2 0 0 5	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Y Aug. 27,	earload M. Co	thplace (State or Foreign ountry) LNE
	Director		212-28-3715 Usual Residence of Decedent	,	115.			Aug. 2/,	1930 Ma:	ıne
	yland 10w		10a. State 10b. County		10c. City, Town or Lo	cation	• • • • • • • • • • • • • • • • • • • •			10d. Inside City Limits
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and	buld be f Mental I arked of atic ava	o Be	Hubert Sheldrake				Grace H		ilden Sumame)	
Maryland 21215-0036	shoul nd Me mark imati	2	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	ıl Route Number, (City or Town, State, 2	Zip Code)
Š	alth a alth a 27 is		G. Donald Carroll, S	Sr. (Husba	18				re, Md. 2	
ore,	es 1 a of He fitam rothe		20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ Rer	manual from Chat-	20b. Place of Dispo cemetery, cren				c. Location - City or	
Ĕ	Pag ment ant: fi		'4 □Donation 5 □ Other (Specify)	noval from State	Parkwood			2005 E	Baltimore,	, Md.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic a gnce.		21. Signature of Funeral Service Licensee	1		. Name and Addres	Inamal Ha	me		
	70 = 4 Q		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	akn	ha daeth Da ast set	7401 Bela	ir Rd. Ba	ltimore,	Md. 21236	
			shock, or heart failure. List only one	cause on each line	ne death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arrest	(₁	Approximate Interval Between Onset and Death
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	death certifica e attending ph id for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.0		hys	9 🗆 Unknown	9□ Unknown						
	og og	by F	PALKINSON'S DISEA		not resulting in the un	nderlying cause give	n in Part I.		-	the cause of death?
ord	w requir been si should	sted	TALE INSEN S DISEN	36				1 Nes	2 P No 3 □ Pr	obabiy 4 Dunknown
Records,	e law has b	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
alF								performe 1 Yes 2		2 🗆 No
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	To tha Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of r: On the basis of e and manner state	xamination and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
	o tha	Me	29b. Signature and title of certifier			29c. License	number	29d.	. Date signed (Month	n, Day, Year)
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ŧ	0/1		30. Name and address of person who com	pleted cause of dea	ith (Item 23a) (Type, I	Print)				
1	V		SERENA K. NOLAN,	4D 883	SATYR H	ice Ro P	ARKVILLE	140	21234	
	Sta	te	30. Name and address of person who com SERENA R. NOLAN A. 31. Date filed (Month, Day, Year) JUL 2 7 2005	32. Registrar	s Signature	P .				
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			State of Maryland / Dep 1 - State State of Maryland / Dep 1 - State of Maryland / Dep 1 - State of Maryland / Dep		, ,	giene Reg. 2. 005 2446	6
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	/Medic Examin	al	Ida May Carroll 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	23, 2005 1:30 4c. County of Death	A M
	LAGIIIII	iei	Suburban Hospital	Bethesda		Montgomery	
	Funeral		5. \$5790 Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day November	h 9. Birthplace (State or Fo	
	Director		377 -03-3041		November	10, 1918 Washington, I). C.
	fand		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City L	imits
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	or 28a-f	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?	
	ath wi		7018 Exfair Road	20814		United States	
	rs after death with the Maryla ", or Items 23a or 28s-f shov raminer must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.	
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∑	and 2 sealth and 2 sealth and 27 is			Exfair Road, Beth			
re,	is 1 ai of Hea Item othe		20a. Method of Disposition 20b. Place of Disposition		Date 27,	20c. Location - City or Town, State	
e e	Pages nent of thant: If Ite		TEBUTAL 2 Cremation 3 Hemoval from State	Heaven Cemetery 20	05	Silver Spring, Maryla	and
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic evant. I'm Medical once.		21. Signature of Funeral/Service Dicensee	22. Name and Address of Facility Obert A. Pumphrey Fune	ral Home/E	Sethesda-Chevy Chase, In	ıc.
	707 e a		23a. Part1. Effer the disease, or complications that caused the death. Do not en	557 Wisconsin Avenue,	Bethesda,	Maryland 20814-3501	
			shock, or heart failure. List only one cause on each line.		or respiratory an	Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death) Congestive Hear Due to (or as a consequence of):	rt Failure		1 day	
	Examiner		Hypertension				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Chart of identifying Cause (Disease or injury			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e en en en en en en en
	ecute and -trans	Examiner	that initiated events				
2 00,	ate be executed obysician and the burial-transit	ai E	Due to (or as a consequence of):				
₹887	tificate ng phys as the	edicai	d				
8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	death certific e attending p od for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
700 m		sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year	r
73 P.0	at the	Phys	9 DOKKNOWN				
7	The law requires that the ate has been signed by th page 2 should be detache	l by I	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part !.		bacco use contribute to the cause of death es 2□No 3□Probably 4點Unkr	
May Vital Record	w requ	Completed			24a. Was a		ulable
May al Reco	The law ate has page 2	dmo			autop	sy prior to completion of cause med?	e of
<u>₹</u> <u>≡</u>	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical	26. Place of Deat			
	S S D	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor		ence 6 Other (Specify)	
10 P	ding Ph. h. After th tuneral		27. Magner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury Injury	Work?	28d. Describe h	ow injury occurred	
sio	Attending r death. ector: After by the tune	cati	2 Accident investigation	M 1 Tyes 2 No			
J. Jo Division	l or Attendated after death Director:	Certification:	4 Homicide 4 Homicide 4 Suicide 5 Suicide 4 Suicide 5 Suicide 6 Suicide 7 Suicide 7 Suicide 8 Suicide	treet, factory, office	City or Tow	treet and Number or Rural Route Number, n, State)	
arro	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	edical C	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, deal control of the basis of examination and/or in the basis of examinatio	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the c	cause(s) and manner as stated. date and place, and due to the cause(s)	- 11
3	o the lithin 2 o the omplei	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
	F 3 F 8		Fran Stall w	51779		July 23, 2005	
ï	1		30. Name and address a per in who completed cause of death (Item 23a) (Type			,,	
_1	U			e Blvd.//300, Rock	kville,	Maryland 20852	
	Sta Registr	2	31. Date filed (Month, Day, Year) 2 7 2005 Regist	7			

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #26 PER PHY G845 Gertificate of Death Reg. No. () [] 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MELVIN SAMUEL CAGEN JULY 2005 16 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 31 STONEHENGE CIRCLE UNIT #6 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/25/1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months 218-18-6257 82 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director FL PALM BEACH DELRAY BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 942 GREENSWARD LANE or Items 23a 33445 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If item 27 Is marked other than Elementary/Secondary (0-12) **EXECUTIVE** PLASTIC EXTRUSIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACOB COHEN ROSE SHAPIRO 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is any injury or other tree once. 942 GREENSWARD LANE - DELRAY BEACH, FL 33445 NORMA CAGEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 07/18/2005 TOWSON, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Keual cell Physician carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) MARYLAND examiner Other: 1 Yes 2 No 4 Nursing Home dence 6XX ther (Specify) RES IDENCE 7 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier PO TO 29d, Date signed (Month, Day, Year) 0 0062254 2005 MA TRUICA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Belvedere Avenue, Baltimore MD 21215 ERISTINA TRUICA, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Tulu **Physician** 10:20 A N Anna Cizdyn /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Keswick Nursing Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 TF 84 213 30 1151 1921 Ukraine Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-fehow other traumatic event, the Medical Exerting Instituted at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5422 Wasena Avenue 21225 U.S. items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2**X**No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ⅓ Widowed 4 ☐ Divorced Year or Dates: "naturei", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.

Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Clothing 7th Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alexander Kotula Maria Bandrowska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type_Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun Marianna Cizdyn / Daughter 5422 Wasena Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael Ukranian 7/29/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 romeco 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final advanced asherner **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown à been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 000 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Magner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Certification: 1 Accident 5 Pending after death. 2 🗌 No 1 Tes investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M Kahelle 113657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
T-JABELLE THERREGOR, 700 W. 40 700 W. 40 KSTREET, BALTIMORE, 17-12MBELLEV 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

			Please T		Indelible Ink. Ensure Al	_	•					
		4	For State Registrar	•	epartment of Health and M Certificate of Death		N2005 24469					
			Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of Death	2. Date of Death	3. Time of Death					
	Physici /Medic		Estelle Rena Driv	ver			Day Year 7:45 PM					
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death					
			5. Nai Hospitul 5. Social Security Number 6. Sex	1	Baltimore C	8 Date of Birth	n/a 9. Birthplace (State or Foreign					
	Funeral Director			M 280 F 72 Yrs	Months Days Hours Min.	Oct. II,	1932 Maryland					
			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits					
	Maryla f show	٥		77 1 . 1			1 Yes 2 No					
	r 28e-	Director	MD Baltimore 10e. Street and Number	naiethoi	10f. Zip Code	10g.	Citizen of What Country?					
	23a o	al D	3006 Ohio Ave.		21227		USA					
	er dea	Funeral	Tr. Marian States	Armed Forces?	 Was Decedent of Hispanic Origin? (Spenif Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	urs aft	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1□Yes X□No Specify: Whi	lte	Specify: white					
Maryland 21215-0036	within 72 hours after death with the Maryland one. then "neturel", or Items 23e or 28e-1 show then "neturel" or Items 23e or 28e-1 show the Modified at the Mo	Completed	15. Decedent's Educ (Specify only highest grade		ecedent's Usual Occupation Give kind of work done during most of work	ing 16b	. Kind of Business/Industry					
121	d within 72 ho piene. r than "natur the Medicul	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired) emaker		Home					
d 2	iled Hygi ther nt,	ø	9th 17. Father's Name (First, Middle, Last)	HOIN		e (First, Middle, Maid						
/lan	o d to b	To B	Robert Meyers		Rena N	ills						
Man	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z									
	s 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or									
I O II			1 ☐ Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place) Park Cemetery July 2	29, 05 Bal	Ltimore City					
Baltimore,	permit. Page Department of Importent: If any injury or ang injury or		21. Signature of Juneral Service Ligense				Funeral Home					
8	99 2 2 2		* HM SI	Vangu	3620 Wilkens Ave.	Baltimore	, Maryland 21229					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do no	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death					
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of)	26 days							
	Examiner		Sequentially list conditions,	b.								
	b sit	amlner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)								
	xecuted and al-transit	~	that initiated events resulting in death) Last	Due to (or as a consequence of)	:							
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89	death certificate be exc e attending physicien a of for use as the burial-	Physician/Medical	IF FEMALE:									
Вох	eath certific attending p I for use as I	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year					
o.	at the de by the a	nyslo	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unknown	J Other (specify)							
s, P	es that igned b	by Pi	Part II. Other significant conditions cor	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?					
ord	w require been sig should b		Diabetes M	ellitus		1 Tes	2 No 3 Probably 4 Unknown					
Records,	e ta has	Completed	Sepsis			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 17 No 1 □ Yes 2 ☑ No					
Vital	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	face the last of t		h (Check only one)						
of \	Phys this al dii	- T	1 Yes 2 No	lospital: 1 Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tir		me 5 Residence	e 6 Other (Specify)					
	ding After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju								
Division	or Attendi efter death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)					
	To the Hospitel or Attent within 24 hours efter deati To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)					

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasturan Rafie; MD, Hospitul of

31. Date filed (Month, Day, Year)

32. Egistrar's Signature



RES - 00 0

Baltinone

July 25/2005

			1 - For Amend #4c&10	State of Ma d Per Inf. &Phy	aryland/Der	partment of h	leaith and N <i>Death</i>	Mental Hygie	ene • • • • • • • • • • • • • • • • • • •	21170
	Physici /Media		1. Decedent's Name (First, Middle, Las	Denn:	is Patien	t Dorsey		2. Date of Death Month	Day Year 23 2005	3:30 a. M
	Examir		4a. Facility Name (If not institution, give 3413 Ripple Roa			4b. City, Town, o	r Location of Death		4c. County of Dea	ath Baltimore
	Funeral Director		212-42-3629	ex 7. Age XM 2□ F	e (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) 6-15-19	ear) C	rthplace (State or Foreign Jountry) Md
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Md	N/A	10c. City, Town or t	ocation				10d. Inside City Limits
	with the ? 3e or 28e-	i Direct	10e. Street and Number 3413 Ripple Roa			10f. Zip Code 21244		10g	. Citizen of What C	Country?
980	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Items 23e or 28e-f ehow event, the Medical Examiner must be notified at	by Funeral Director	11. Marrial Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 1 Yes 2 □ N If Yes, Give Year or Dates:		Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	U S A 14. Race - Am Black, Whi	
21215-0036	c * 3	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ing	owson Sta	s/Industry te University				
Maryland ?	should be filed within nd Mental Hygiene. Imarked other than Imatic event, the M	To Be C	17. Father's Name (First, Middle, Last) John Henry Dorsey			nt Engine	18. Mother's Nam Goldie			
	and 2 salth ar n 27 is		19a. Informant's Name/Relationship (7) Brenda Dorsey — 1 20a. Method of Disposition			ling Address (Street	Road Ba	1to, Md 2	1244	
altimore,	t. Page rtment o rtant: If		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Liceo)	Garriso	n Forest	Vet 7-29		c.Location - City of rings Mill F/H West	
Ba	permi Depa Impo any Ir		23a. Part. Enter the disease, or comp	olications that caused	The death. Do not e	43	00 Wabash	Avenue	Balto, M	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a Metas	static a consequence of):	Colore	ectal (Cancer		Interval Between Onset and Death 22 Months
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, and any, because the underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
.O. Box 6	The law requires that the death certificate ite has been signed by the attending physion 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy	/		23d. Date of de Month	Divery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions or	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		,	o the cause of death? robably 4 Dunknown
Il Records,	(Q CT	Completed						24a. Was an autopsy performer	d2 death?	utopsy findings available completion of cause of
Vital	5 6 9 9 P	o Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	h (Check only one)		
of	After une	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y 28b. Time	of 28c. Injur	y at	me 5 K Residenc 28d. Describe how		ecify)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in k	Medical	(Check only 2 Medical Exeп	ysicien: To the best of iner: On the basis of and manner sta	examination and/or i	nvestigation, in my o	pinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
,		2	29b. Signature and title of certifier	oper my		29c. Licens	6 118	29d.	Date signed (Mont	in, Day, Year) 12005
	Sta	ite	30. Name and address of person who of the control o	IPER MI	eath (Item 23a) (Type	7 YOR	k Rd	Luther	ville r	10 21093
	Registr	ar	JUL 2	7 2005	Cours S.	brown				

			1 - For State Registrar	state of Maryla		artmen:			nd Mental H	lygien Reg. N	71115	24471	
	Physic	ian	Decedent's Name (First, Middle, Last) ROBERT RICHARD DEN	IMIZINI					2. Date of		^{ay} 2005 ^{Year}	3. Time of Death	
	/Medi Examii		4a. Facility Name (If not institution, give stre			4b. City.	Town, or	Location of E		· · · · · ·	c. County of Death	10:00 P M	
	Cydilli	iÇi	#320 Morning Dove N				old		-		Anne Aru		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	If Under Months	1 Year	If Under 24 Hours	Hrs. 8. Date of Min.			nplace (State or Foreign untry)	
	Director		144-32-4310	^{2□ F} 65	Yrs.	WOILLIS	Days	Hours	Hrs. 8. Date of (Month, 4/27/	1940	New	Jersey	
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Lim		
	Mary -f eh	to	Maryland Anne Arunde	_	nold							1∐Yes 2∭No	
	h the	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Cor	untry?	
	th wit	a D	#320 Morning Dove V	<i>l</i> ay		210	012			τ	JSA		
	r dea	ner		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of His	spanic Origin n, Mexican, P	? (Specify Yes or Puerto Rican, etc.)		14. Race - Amer Black, White		
36	or li	by Fu	1 ☐ Never Married 2000 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	959-	1 ☐ Yes 2		Specify:	,		Specify: Whi		
5-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Alsol Exertinet matter routiled at	ed	15. Decedent's Educati	on I	965 16a. Dece	dent's Usua	I Occupa	ition		16b	Kind of Business/I	ndustry	
215	within 73 ene. than "n	ple	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d	lurina mast oi	f working				
2	filed with Hygiene. other than	Completed	4		Manuf	actur	er's	Rep.		Car	peting		
nd	tal Hi	Be	17. Father's Name (First, Middle, Last)						Name (First, Midd				
Maryland	init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortent: if item 27 is marked other than "natural", or items 23a or 28a-f ehow injury or other traumatic event, if a Madical Exercitors result by ruffilled at injury or other traumatic event, if a Madical Exercitors results by ruffilled at 8.	Jo	Lester F. Denman	D-f-Al	405 14.78		(2)		hy Flore				
Ma	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Type, Mary E. Denman/Wife	Printi					or Rural Route Num lay Arnolo			ip Code)	
	as 1 and 2 of Health in tem 27 in other tree		20a. Method of Disposition	20b.	Place of Dispo				Date Date	_	Location - City or T	own, State	
Baltimore,	Pages ent of nt: If it ry or c		1 ☐ Burial 2√ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Oval II Olii State	cemetery, crei alas Cr				23/05		gewater,M		
alti	permit. Pages Department of Important: If i any injury or once.		21. Signature Funeral Service Lisensee	/	GEORGE P.								
m	Depar Impo		Art Kales	, 1	LAND ROAL	D. EDG	EWATER.	MD. 21037					
	Physician /Medical Examiner		23 P.int. Enter the dilease, or companies sock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	rdiac or respiratory		v	Approximate Interval Between Onset and Death Y Myd						
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
Вох 68	death certifica attending phatfor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregi		Ectopic pre	egnancy				23d. Date of deliv	•	
0	at the des by the a tached f	ysic	1 TVas 2 TNo	4□Pregnant at time of 9□Unknown	death 5	Other (spe	ecify)				Month	Day Year	
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying ca	luse give	n in Part I.		tobacco Yes 2	_	the cause of death?	
000	ne law re has bee	Completed							24a. W		24b. Were auto	opsy findings available	
Ä		Com								opsy formed? 2 No	death?	ompletion of cause of	
Vital	yaician: is certific director,	Be (25. Was case referred to medical examiner?		M.			26. Place of	Death Check onl	-/			
of \	Phyaician: this certific ral director,	2	1 Yes 2 No Hosp	1 Unpatient 2			_	4 Nursir			6 ☐Other (Special	fy)	
	ling After fune	lou		8a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? es 2 □ No	28d. Describ	e how inju	iry occurred		
Division	or Attending after death. Director: After in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At I	nome farm str			es 2 INO	28f Location	(Street a	nd Number or Run	al Route Number	
	al or A after I Direct	Certification:	4 Homicide	building, etc. (Spec	ify)	oot, ractory,	OHIOO		City or T	own, Stat	e)	ar riodie rydriber,	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier Certifying Physicia (Check only one) Certifying Physicia (Check only one)	an: To the best of my kn On the basis of examin and manner stated.	nowledge, death	occurred a restigation,	it the time	e, date and p inion, death o	place, and due to the	e cause(s	s) and manner as s d place, and due t	stated. o the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	1 2	1.1	29c.	License	number		29d. Da	ate signed (Month,	Day, Year)	
)	17/		The Charle	1 1	ens 1	W	D マ	1438		n	My 22	1001	
(0		MICHAEL J. [eted dause of death (tte	A My	1451	Def	ense [dighum	, A	WWAPULI.	Mnziyu	
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 7 2005	32. Registrar's Sign	Coarle		,		·	/			

			For State Registrar	State of Mary		artment of H		, ,	jiene)5 2	447	12
	Physici		1. Decedent's Name (First, Middle, Las Mildred M. Dre	,				2. Date of Dea Month Jul 21	th Day	Year	3. Time of D	eath D M
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County			Ρ
			Anne Arundel M			Annapol		T		Arun		
	Funeral Director		5. Social Security Number 6. S 213-01-8771 Usual Residence of Decedent	D M 2√2 F 91	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 11	, Year)	9. Birthplace Country Maryl		=oreign
	yland how		10a. State 10b. County	100	c. City, Town or Lo	cation				10d.	Inside City	Limits
	88-fs	ctor	Maryland Anne Arı	ındel	Annapol:	is					1 ☐ Yes 2	!⊠ No
	with the a or 2	Funeral Director	10e. Street and Number			10f. Zip Code	2		10g. Citizen of V	Vhat Country	?	
	ms 23	eral	295 Edgemere Drive	12. Was Decedent Ever	in U.S. 13.1	2140 Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	USA 14. Rac	e - American	Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show appring to other traumatic event, if a Medical Eventire trust is a notified at 2008.	by	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	•		in, Mexican, Puert Specify:	o Rican, etc.)	Specify	ck, White, etc.	ite	
15-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Bu	usiness/Indus	try	
12	filed within Hygiene. Ither than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Maker	"	1	Own Ho	me		
br	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumam			
ylar	2 should be fi and Mental H is marked of aumatic ever	ToE	Anthony Wagner				Wilhelm	ine Koeh	ler			
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (19aul V. Dresler /	** *		ng Address (Street a						1
	Health tem 27 other tr		20a. Method of Disposition			Declan Consistion (Name of place of place)		Date	20c. Location -			
E C	Pages nent of l int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☑ Donation 5 ☐ Other (Specify	Dellioval II Olli State		natory or other piac n Mem。Pk		5/05	Marriot	tsvill	e. Mai	rvlan
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Sinn ture Funeral Service Licer			2. Name and Addres	_	ubbard F				- J - La.
	2012		Thing	South		107 Wilke	ns Avenu	e, Balti	more, M	arylan	d 2122	29
R			23a. Part1. Entel the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory arr	est,	Int	pproximate terval Betwe nset and De	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	eumon	-				- 4		
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8760,	ate be ex hysician the burial	dical E	l l	d								
9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medic		<u> </u>								
Вох	leath certifica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Dat	te of delivery	ıy Ye	ar
0.	he de	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)					, , , ,	
σ.	res that the designed by the		Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the o	ause of dea	ath?
Records,	w requires been sign should be	ed by						1 🗆 Y	es 2. No	3 Probabi	y 4 ∐Uni	known
9 0 0	e law requ has been ge 2 shouk	Completed						24a. Was a		Nere autopsy	r findings av	allable
E B		Con						perfor	med?	death?	□ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth all Dos Oth	00	ath (Check only or				
of	Phys or this oral di	7: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o	IL SEL DON	4 🗆 Nursing F	lome 5 Resid				
ion	Attending r death. ector: After by the fune	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury		k? Yes 2 □ No					
Division	in Site	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural R	oute Numbe	9 <i>1</i> °,
	To the Hospital within 24 hours a Fo the Funeral I	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occu	, and due to the d rred at the time, o	ause(s) and ma date and place, a	and due to the	id. e cause(s)	
	To the within 2 To the complet	∑ V	29b. Signature and title of certifier	finos.		29c. License	9 number 4/8/E	2	29d. Date signed	(Monthy Day	v, Year)	
1	00.			elps and	(Item 23a) (Type 35 0(8)	Print Journal	I land	RD.	Annepo	lis N	10 2	1401
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A			,			
DH	MH 17 Rev 1/2		JUL 2 7 2	005 Maria	B A	osili						
				,	ORIGINA	AL.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Michael Year Brian Davisson 19, 2005 July 8:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Convalescent Center Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months 49 **Director** 467-17-7563 24.1956 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 ia marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Executions required at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2656 Hunt Place Apt. 102 20602 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1076 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 ia marked other than "natural", or Item any injury or other traumatic event, the Medical Exercitives 2008. NG Yes 2 No 1976− NG Yes 2 No 1976− NG Yes, Give Year or Dates: 1980 Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White A A 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerk Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Earl Davisson Patricia Jane Banner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne J. Davisson 2656 Hunt Place Apt. 102 Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 25, 20c. Location - City or Town, State 1 X Kurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 2005 Cheltenham Maryland 21. Sig at wo of Fune al of rvice Life nse 22. Name and Address of Facility Lee Funeral Home, Inc. Mus J. 6633 OLd Alexandria Ferry Road Clinton, MD20735 trai M00257 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pruemonia /Medical Due to (or as a consequence of): Examiner Muscular Dystrophy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 99 cate has been sig., page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 X No certificate Division of Vital 1 🗌 Yes 1 Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 - Homicide 24 hours a 1 Cretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 70 29c. License number 29d. Date signed (Month, Day, Year) 20, 2005 Comen 5 D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM T. TANNER MY 11701 Livingston RD Suite 101 Ft. Washignton MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Maryland	-	tment of He				
	Physici /Medie		1. Decedent's Name (First, Middle, Last) WIZLIE M DIX				2. Date of Dea		3. Time of Geath
	Examir		4a. Facility Name (If not institution, give street and number) BOY SECOUS HOSE 5. Social Security Number 6. Sex 7. Age (In yrs. I	. 1	4b. City, Town, or L 3ALT. If Under 1 Year	ocation of Death	8. Date of Birth	4c. County of	Death LTMOKE Birthplace (State or Foreign
	Director		2/2-16-5970 1□M 2ØF 8 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	March	P, 1921	South Carolin
	the Maryia 28e-f shov	Director	10a. State 10b. County 10c. City 10e. Street and Number	y, Town or Loca	Battino,	re		Og. Citizen of Wh	10d. Inside City Limits 1 Tes 2 No
	ath with 23a or		2901 Presstman St.			1216		V.	ISA
980	hours after death with the Maryland tural', or items 23a or 28e-f show at Examinet must be multitled at	by Funeral	11. Maritat Status 1 Newer Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.: Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:		as Decedent of Hisp res, specify Cuban, Yes 210 No	panic Origin? (Spi , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	Americen Indian, White, etc. Black
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	1 and 2 sh Health and em 27 is rr ther treum		19a. Informant's Name/Relationship ype, Print) Deborat Anderson-daughter 20a. Method of Disposition 20b. Pi	3505 lace of Dispositi	Address (Street and Solution (Name of	Rd.	Battin	City or Town, Sta Color 20c. Location - Cit	ryland
Baltimore	Page nent o ant: If ury or		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crema:	Torat V Name and Address	et. Cen. 8	11/05 0	wings	Wills, Marylans
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f Vita	Physicien: this certificantal director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 patient 2 I	ER/Outpatient	3 DOA Other:	26. Place of Death		e ence 6 □Other(Specify)
on of	De te		27. Mann of Death 1 atural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	it :		w injury occurred	
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	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Exeminer: On the basis of examinat and manner stated.	tion and/or inves	stigation, in my opin	nion, death occurr	ed at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	o time o	/	29b. Signature and title of certifier Slauds 72 - Singer	MD	29c. License n	number 2559	2	9d. Date signed (A	
0	1		30. Name and address of person who completed cause death (Item	23a) (Type, Pri	PETAL	/		-	
***	Sta Registi	ate rar	30. Name and address of person who completed cause death (Item Box 31. Date filed (Month, Day, Year) JUL 2 7 2005	ture	i)				

Anna 05–4 AKG

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4978		For State	State of Ma	ryland / Depa	artment of <i>rtificate o</i> f			309. N2 0 0 5	21.1.75				
্ কা	4 2	Registrar 1. Decedent's Name (First, Middle, L	ast)	OB,	runcate of	Dealii	2 Date of Dea	ath	3. Time of Death				
Physic		Anna Dviny	,				July 2	23, 2005 Year	6:34 P M				
/Med Exam		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town,	, or Location of Deat		4c. County of Dea					
	- E	500 South Kenwoo	d Avenue		Baltimon	re		n/a					
Funera		Social Security Number 6.		(In yrs. last birthday)		r If Under 24 Hrs	(Month, Da)	h 9. Bir y, Year) C	rthplace (State or Foreign ountry)				
Directo		218-36-8356 Usual Residence of Decedent	ILM ZELF	79 Yrs.			4/2/2		ustria				
and		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
Mary I-f eh	ţ	Md	n/a	Bal	timore				1 XYes 2 □ No				
h the	Irec	10e. Street and Number	117 4		10f. Zip Code) -		10g. Citizen of What Country?					
th wit	Funeral Director	500 S. Kenwoo	d Ave.			21224		USA					
r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	s or No- ltc.) 14. Race - American Indian, Black, Whife, etc.					
36 s afte	by Fu	1 Never Married 2 Married 3 Wildowed 4 Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:)	1□Yes 2⊠N			Specify:					
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. whe than "natural; or Itams 23s or 28s-f ehow ant, the Madical Examal at must be notified at	P P	15. Decedent's		16a Dece	dent's Usual Occ	upation		White 16b. Kind of Business/Industry					
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Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic event, the Madical Examinat must be notified at			19a. Informant's Name/Relationship (Type, Print) Mr. Ehor Hadzanan 19b. Mailing Address (Street and Number or Rural Route No. 2005) 3005 Dubois Ave. Balti										
e, N 1 and 1 and Health Health ther tr		Mr. Ehor Hadz 20a. Method of Disposition	ore Md.										
Pages nent of I ant: If Ik		1 □ Burial 2 ☑ Cremation 3	20c. Location - City or Town, State										
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4		23a. Part1. Entey the disease, or co shock, or heart failure. List on	on plications that caused	the death. Do not en	ter the mode of d	ying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between				
Physician		Immediate Cause (Final disease or condition	Hr.	co fuele					Onset and Death				
/Medica		resulting in death)	a Due to (or as a	con uenc of):									
Examine		Sequentially list conditions,	b										
ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):									
60, be executed ician and buriat-translt	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):									
m 9 -	calE		d										
Box 687 eath certificate attending phy.			· · · · · · · · · · · · · · · · · · ·										
Box eath cert attending for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		⊒Ectopic pregnar	nev		23d. Date of de	,				
O. E. B. dea b. dea he att	sici	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t		Other (specify)			Month	Day Year				
15, P.O. I	Phy	Part II. Other significant conditions	contributing to death bu	t not resulting in the I	Inderhing cause	given in Part I	23e Did to	obacco use contribute	to the cause of death?				
Division of Vital Records, P.O. Box 68 to attending Physician: The law requires that the death certifica affer death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the control of the con	qp	, <u> </u>		that rooming in all of	indony ing daddo ;	g	101		Probably 4 Unknown				
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vision of Vita Attending Physician: r death. setor: After this carific by the funeral director,	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 3 DOA				ecify) at scene				
ng Pł		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) Injury	W	jury at Vork?	28d. Describe I	now injury occurred					
SiO tendi leath. tor: A	catl	2 ccident investigat	he	1.0 -0		Yes 2 No	+ · · · · · · · · · · · · · · · · ·	Subject Horged SELF					
Division of Attend after death I Director: y	Certification:	4 Homicide determine	building, etc		treet, factory, offic	28	City or Tov						
Hospital of the hours all property filled in stelly filled in		29a. Certifier 1 ☐ Certifying	Physician: To the best o	TA ITOME	th occurred at the	time date and plac		COUDAUT BA					
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2X Medical Ex	aminer: On the basis of and manner stat	examination and/or in	nvestigation, in my	y opinion, death occ	urred at the time,	date and place, and du	e to the cause(s)				
To the within 2. To the complet	M	29b. Signature and title of certifier	-0 -1		29c. Lice	nse number		29d. Date signed (Mor					
1		Walkite.	The You	U		OCME		July 24,	2005				
12		30. Name and address of person wh	no completed cause of de	ath (Item 23a) (Type		Donn Char	ot D-1+	imore 3/-	-1 and 01001				
		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	LLL .	reili Stre	et part	more, Mary	vland 21201				
S Regis	tate trar	JUL 2 7 20											

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-			State of Man	viana /	Department of Health and	mental Hygien
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Physician
/Medical
Examiner

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other freumatic event, the Medical Examinar must be inclined at once. To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1	State Unpend Item 2 Registrar	23a,27,28a-	per me	Riffcate d	15085t/tas		Reg. No.	0.0-	
	Decedent's Name (First, Middle, Las	t)				Month	ath Day	UU5	3 Time of De th
	Andrew T.	Elmore		4h City Tow	n or Location of Deat		4c Cc	2005 ounty of Death	9:22 A M
								altimor	e
7			In yrs. last birthday			8. Date of Bir	th.		place (State or Foreign ntry)
-	218-63-3438 Usual Residence of Decedent	direw T. Elmore solidiy Name (Frist, Middle, Last) ### Cay, Town, or Location of Death Rosedale all Security Number ### Age (in yrs, last pirthday) ### Turber 19ar Turber 24 Hs. 8, Date of Big ### Age (in yrs, last pirthday) ### Turber 19ar Turber 19ar		2002_		zland			
	10a. State 10b. County	11	0c. City, Town or L	ocation.					10d. Inside City Limits 1 ☐ Yes 2 X No
	Maryland Baltimo	re	Middle R	1					
	10e. Street and Number						10g. Citizei	n of What Cou	ntry?
-			or io 11 C 12			Poorty Von or No		S. A. Race - Ameri	can Indian
	11. Marital Status	Armed Forces?	9F IN U.S. 13.	If Yes, specify (or Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.))- 14.	Black, White,	
	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give		1 ☐ Yes 2 ☐	No Specify:		S	рес <i>ify:</i> Whi	te
	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deci (Giv	edent's Usual O	cupation one during most of wo	rking	16b. Kind	of Business/Ir	ndustry
•	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT USO R	urea)		27/2		
-	N/A 17. Father's Name (First, Middle, Last)		N/A		18. Mother's Na	me (First, Middle	N/A Maiden Su	ımame)	
1					Ctrondo	lxm	Elmore	0	
l		Гуре, Print)	19b. Mai	ling Address (St					p Code)
			that)						21220 Maryland
Ì	20a. Method of Disposition	101, 01.	20b. Place of Disp	osition (Name o	f place)	Date		tion - City or T	
						7/28	Balt	imore	Maryland
İ	21. Signature of Funeral Service Licen			22. Name and A	ddress of Facility				
	Muchael C. 2	Jaklim 5		407°81a	ski Funera Eastern A	L Home F venue f	A ssex,	Maryla	and 21221
	23a. Part1. Enter the disease, or comp	plications that caused the	e death. Do not e	nter the mode of	dying, such as cardia	c or respiratory a	rrest.	ncenit	Approximate Interval Between
		Anomalies	With Cen	itrally"	Mediated E	hdocrine	Diso	rder	Onset and Death
	resulting in death)	Due to (or as a	consequence of):						
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	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):						
	that initiated events	c							
	Tooling in doding and	Due to (or as a c	consequence or);						
	•	_ d							
	IF FEMALE:	23c. If yes, outcome of	pregnancy				23	d. Date of deliv	(87)
	in the past 12 months?	1☐Live birth 2	Fetaf death 3				25	Month Month	Day Year
				- Garier (speed	//				
	Part II. Other significant conditions	ontributing to death but	not resulting in the	underlying caus	e given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
						10	Yes 2	Ano 3⊡Pro	bably 4 Unknown
								24b. Were aut	opsy findings available
			<u> </u>			perf	ormed?	prior to co death? 1 1 1 1 es	ompletion of cause of
	25. Was case referred to medical				26. Place of De		2□No one)	11000	2 1 100
	examiner? 1 ∑ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpati	ent 3 DOA	Other			Other (Spec	ny at scene
	27. Manner of Death	28a Date of Injury	28h Time		Injury at		———A		unk
	2 Accident vinvestigation	ⁿ	FOUNT	ATA					
		e 28e. Place of fnjury	/ - At home, farm, : (Specify)	street, factory, of	fice	28f. Location City or To	(Street and wn, State)	Number or Rui	ral Route Number, KINGSWAY
		FOUND AT	RESIDENC	E		ESSEX,	MARYL	ănd ".	KTHOOMVI
	(Check only 2X Medical Exar	miner: On the basis of e	xamination and/or	ath occurred at t investigation, in	ne time, date and place my opinion, death occ	e, and due to the surred at the time	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	29b. Signature and file of certifier	- I state		29c. L	cense number		29d. Date	signed (Month	, Dey, Year)
	•	11 1			OCME			23, 20	
	30. Name and address of person who	completed cause of dea	th (Item 23a) (Typ.	e, Print)				•	
	MARY	G-RIPPL	A A O		Penn Stree	et Balt	imore	, Maryl	and 21201
	31. Date filed (Month, Day, Year)	32 Registrar							
	JUL 2 7 200	05 Kelena	15	rele					
		1	-	1 12 2					

State

Registrar

			1 - For State Registrar	State of Marylan				ealth a Death			Reg. No	2001	5 2447	17
	Physici	an	1. Decedent's Name (First, Middle, Last) Mera Helen Ford						2	2. Date of Dea Month	Da		3. Time of Deaf	M.
	/Medic Examin		4a. Facility Name (If not institution, give s Saint Joseph M	street and number)	t p x	4b. City	Town, or	Location of	Death	JULY		County of De	ath	
			5. Social Security Number 6. Sex			If Unde	r 1 Year	If Under 2		B. Date of Birt	h		timore	
	Funeral Director			M 2□ F 71	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)		rthplace (State or Fore country)	·9··
	and w		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation				210 / 01110			10d. Inside City Lim	its
	Maryli f eho	Ď	Maryland Baltimore	Dung									1 Tes 2 1	
	or 28a	irec	10e. Street and Number			10f. Zi	Code				10g. Cit	tizen of What C		-
	ath wil	raiD	8108 Stratman Road				222_				USA			
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23e or 28e-f ehow of other than "natural", or items 23e or 28e-f ehow event, the Medical Examinat must be motified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 및 Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece f Yes, spe 1 ☐ Yes	cify Cubai	spanic Orig n, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Arr Black, Wh Specify:		
2-0	72 hou	ted	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usu	al Occupa	ition	of working	2	16b. K	ind of Busines		
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Secreta		ise retired,	luring most	-		MD	Dont o	f Transportat	ion
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lan	should be nd Mental marked c	To Be	Nicholas Alexander	Szkola				Mary	Barba	ra Bl <i>a</i> c	kiew	icz		
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is merke other traumatic	Γ,	19a. Informant's Name/Relationship (Ty	pe, Print)	1	•						or Town, State,	Zip Code)	
	l and lealth em 27 her tr		Mary-Jo Ford	20h F		1			more,	Md. 212		ocation - City o	r Town State	-
Baltimore,	6 O		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ P	temoval from State	Place of Dispo cemetery, crei									
altin	무문판 글		* 4 □ Donation 5 □ Other (Specify) 21. Sometime of Funeral Service License		kwood G	2. Name a	nd Addres	s of Facility	1000		Bal	timore,M	arylam.	
ñ	Depa Impo any ii		23a. Part1. Enter the disease, or compl	to home	1 2			neral H						
8760,	ate be executed / Medical and / Medician and ithe burial-transit	ilcal Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it by leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect Due to (or a) due to (D BLAI uence of): uence of):								Interval Between Onset and Death	
.O. Box 6	at the death certificate by the attending phys hached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	Ideath 3	⊒Ectopic ρ ⊒ Other (s						23d. Date of d Month	elivery Day Year	
Δ.	uires that n signed b	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did t		_	to the cause of death? Probably 4 □Unkno	
I Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed								24a. Was autor perfo		prior to death?		ble of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only o				
of	ing Phys Viter this Ineral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	4 🗆 Nur	28	e 5 Resided		6 □Other (Sp iry occurred	ecify)	
Division	af or Attendi s after death. at Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, facto	y, office		28	3f. Location (City or To	Street a vn, Stat	nd Number or i	Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formal of the formal or	Medical (sician: To the best of my knoner: On the basis of examinating and manner stated.										
	To the within 2. To the complet	Ž	29b. Signature and title of certifier	ellin.	,	29	c. License	number			29d. Da	ate signed (Mo	nth, Day, Year)	
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	Oi		30. Name and address of person who co					dem 4 11 - 112 112		din sen :		,	(
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2 7 200	7 Registrar's Sign	ature	RIVI	-, T	OWSOI	N, M	ARYLA	ND	21204		

		1	For State Registrar	State of	Marylan	-	artment o			Mental Hy	giene Reg. No	_	21.1.78
/N	ysicia ledic	in al -	Decedent's Name (First, Middle, Las BESSIE FRANK Facility Name (If not institution, give		ber)		4b. City, Toy	vn. or Locati	on of Deat	2. Date of Dea Month JULY	Day 15	Year 2005	3. Time of Death 11:30 P M
Exa	amine	er	8100 CONNECTICUT AVE				- 71	CHASE				NTGOMERY	
Fund Direct			030 32 3033	x □M 2 X XIF	. Age (In yrs. 101	last birthday) Yrs.	If Under 1 Y Months D	ear If Unays Hou	der 24 Hrs rs Min		h y, Year) 1903	9. Birtl Co NEW	nplace (State or Foreign untry) YORK
Maryland	fied at		Usual Residence of Decedent 10a. State 10b. County MD MONTGOME	RY		y, Town or Lo							10d. Inside City Limits 1 X Yes 2 No
with the	st be not	اۃ	10e. Street and Number 8100 CONNECTICUT AVE	NUE			10f. Zip Co 20815				10g. Citi	zen of What Co USA	untry?
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aryland 2 should be filed a and Mental Hygie	atic evant,	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Mailing Address (Street and Number or Flural Route Number, City or Town, State, THEODORE FRANK / SON 5505 POLLARD RD, BETHESDA, MD 20816									·		
TORE, INTERVIENCE A LAIS-UNGO gos 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28a-1 show	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of THEODORE FRANK / SON 20a. Method of Disposition 1										ocation - City or	Town, State	
Baltimore, parmit. Pages 1 and Department of Healt Important: If Itam 2	any injury once.		21. Signature of Funaral Service Licen		D) WAS	22	. Name and A	ddress of Fa	icilityFLE	CCK FUNERAL , LAUREL,	HOME	KLYN, NEW E INC. 0707	YURK
Pnysic /Med	_		23a. Part1. Enter the disease, or come shock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death)	a. END	ch line.	AGE	-			LER'S	-	SEASE	Approximate Interval Between Onset and Death
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Div To the Hospital or within 24 hours afte To tha Funeral Dir.	completely filled in by the funeral	edical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the liner: On the ba and mann	sis of examina	owledge, deat ation and/or in	vestigation, in	my opinion,	death occ	urred at the time,	date and	d place, and due	to the cause(s)
or with or	con	×	29b. Signature and title of certifier Mülyu			y My	1 0	351	791		7	te signed (Monti	5
10 '			30. Name and address of person who MERLYW VEMU 31. Date filed (Month, Day, Year)	RYMC	98	2 a) (Type,	Print) ORGI	7 Av	E,S	UITE 22-	7,5	ILVER	SPRING, MI 2090 2
Re	Sta gistr		JUL 2 7 20		egistrar's Signa	y Son	de						2090 2

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Year JULY 8, 2005 **Physician** JOHN ANTHONY FUNKE 9:06A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE CLINTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT. 25, 1949 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 💢 M 2 🗆 F WASHINGTON, DC Yrs Director 220-76-5427 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a State 10b County 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic avent, its Macteal Examinar must be notified at PRINCE GEORGE CLINTON XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6502 SPRINGBROOK LANE 20735 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "naturel', or Item any injury or other treumetic avent, Ite Medicul Examinations. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE N/A Ø 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ FREDERICK A FUNKE TERESA W. DIETRICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ODELIA C. FUNKE / SISTER 5308 RENO ROAD, N.W. WASHINGTON, DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BLADENSBURG, MARYLAND FT. LINCOLN CEMETERY 7/13/05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEYM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1 Yes 2 INO Hospital or Attending Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11116 Mij D 7-09-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20031 henal 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 2005 Registrar

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	Physici	an	Registrar Decedent's Name (First, Middle Jerome J. Gra						imouto or	Douth		2. Date of De Month July	eath Day	Yea	3. Time of Death	
I	/Medio Examir		4a. Facility Name (If not institution 1257 Linden A	n, give s		mber)			4b. City, Town, o		of Death	oury	4c. 0	2005 County of De Balti	ath	
	Funeral Director		5. Social Security Number 216-42-6174 Usual Residence of Decedent	6. Sex	:]M 2□F	7. Age	(In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bid (Month, Da NOV • 1	rth ay, Yea <i>r)</i> 9, 19		irthplace (State or Foreig Country) Maryland	n
	the Maryland 28a-f show	Director	10a. State 10b. County MD Balti 10e. Street and Number		2		10c. City Arbu	, Town or Lo					10- Citi-		10d. Inside City Limits	
· 0	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "neturel", or items 23e or 28e-f show other then "neturel", or items 23e or 28e-f show event, I're Maralcal Extractified at	Funeral Dir	1257 Linden 11. Marital Status 1 \(\triangle \text{Never Married} \) 2 \(\triangle \triangle \text{Mar} \)		1UC 12. Was Deci Armed Fo 1 XYes	rces?	_	IV I	10f. Zip Code 2122 Was Decedent of Ff Yes, specify Cub		igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	US		nencan Indian,	
15-0036	in 72 hours a "neturel", o	Completed by	3 Widowed 4 Divorced 15. Deceder (Specify only highe	t's Educ	If Yes, Gir Year or D cation a completed)	ve lates:		16a. Dece	1 ☐ Yes 2 ☒ No dent's Usual Occup kind of work done DO NOT use retire	during mos		ng		Specify: W		
and 2121	be filed Ital Hygi od other	Be	17. Father's Name (First, Middle, Jerome G. Gra	,	College (1-4or 5+ L	+)		-employed	Cont	er's Name	or (First, Middle ie Macz	, Maiden S	Painti Sumame)	ng	_
Mar	nd 2 sh lith and 27 is m r treum	To	19a. Informant's Name/Relations Darlene Grace	hip (Ty)					ng Address <i>(Street</i>	and Numbi	er or Rura	l Route Numb	er, City or	, Zip Code)		
Baltimore,	it. Page rtment o rtent: If njury or		20a. Method of Disposition 1	pecify)		20b. Place of Disposition (Name of cametery, crematory or other place) Baltimore Wash. Crm. 7/30/2005 22. Name and Address of Facility Gary L. Kautman Funeral F							Laı	ırel,		
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Division of Vital Records,	To the Hospital or Attending Physicien: whin's 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director;	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendii	1 ☐ Yes 2 ☐ Mo ☐ Hospital: 1 ☐ Inpatier 27. Manner of Death 1 ☐ Natural 5 ☐ Pending							rsing Hor	(Check only one 5 D Resi	dence 6		ecify)	
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10	'4		30. Name and address of person L. Austral Day (e, w	mpleted caus	re of de	ath (Item	23a) (Турв. m Саи	Print) Cer Ctr.,	22 S	· 52	zare St	Bo	ltmor	u, ma 2120,	<i>i</i>
	Sta Registi		31. Date filed (Month, Day, Year,		005	le de	rs Signat	J. A	barte							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 19, 11:11 P M July 2005 ANNE CORINNE **GOHEGAN** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day Year) April 12, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 25 83 1922 215-12-8507 Yrs **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State show r than "neturel", or Items 23e or 28a-f show The Worldail Expedience was becomified at 1XXes 2 □ No Frederick Frederick Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 212 Lindbergh Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned or J Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home permit, Pagas 1 and 2 should ba filed w Department of Health and Mental Hygier Importent: If item 21 is marked other it any injury or other treumatic event, IIIs once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Corinne Whiteford Walter Leo Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 Lindbergh Ave., Frederick, Maryland 21701 John R. Gohegan, Jr., husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State July 23, 2005 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Reenev and Eastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Da disease or condition resulting in death) Uneumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown Lealt Facily+ E 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Stenosis tor HIC has le 2 2□ No certificate 1 TYes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d, Date signed (Month, Day, Year) 29b. Signatu re and title of certifier Hiran mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 not 31. Date filed (Month, Day, Year)
JUL 2 7 2005 32 Tegistrar's Signature State Registrar

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Reg	Sta istra		31. Date filed (Mor		7 2005	Registrar's	Signature	4	ande	,							

7/26/05 at 031544

PATRICIA ANN HAMILTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		1 - State Registrar		C	ertificate of Dea	ath	Reg. No 2 1 1	5 21.1.81.
- 13		1. Decedent's Name (First, Middle, La	st)			2. Date of I	_	3. Time of Death
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DIVISION if or Attending after death. i Director; After	Certification;	3 Suicide 6 Could not be determined		y · At home, farm, (Specify)	street, factory, office	28f. Location City or 7	(Street and Number or own, State)	Rural Route Number,
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To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner state	ed.	29c. License num		29d. Date signed (Mo	
F ₹ F 8		230. Signature and time of deliver	1 /2		O.C.M		JULY 25,	
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U	an increase of	30. Name and address of person who	C A DDI K		· ·	AT DITAME	SZT ABID 01001	
	tate	31. Date filed (Month, Day, Year)	32. Registrar		INN STREET, B	ALITMORE, MAR	YLAND 21201	
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1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Catherine Loraine Hargett July 23 1:00am M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 512 Schley Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Min. Months Days Hours Yrs **Director** 214-34-9313 84 May 16, 1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28e-1 show other treumatic event. The Medical Examinar must be notified at 1√Xes 2□No Directo Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Schley Avenue 21702 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑Xio Specify: White þ 3 XWidowed 4 □ Divorced Be Completed 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene Importent: If Item 27 is marked other that any injury or other treumatic event, Item 2008. Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stotler Charles Lauran Mary Rudisill Anna ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Earl F. Hargett, Jr/Son 512 Schley Avenue, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery July 27,2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signature of Funeral Service Licensee M00706 Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Colon Cancer disease or condition resulting in death) 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause) Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only Medi one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D41866 July 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, M.D., 46-B Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 2005 3. Registrar's Signature State Registrar

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		•	For Stata Registrar	otato or marya	•	tificate of l			2.00	5 24486
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	Funeral Director		5. Social Security Number 6. Sex		vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 18	Year)	9. Birthplace (State or Foreign Country) Maryland
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel; or Items 23e or 28e-f show or other treumatic event, the Medical Examiner must be rutillised at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of Hif Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	e-American Indian, k, White, etc. White
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	and 2 sho ealth and I m 27 Is me		19a. Informant's Name/Relationship (Ty Frank Hill / Hush			ng Address (Street a	and Number or Rura nue Ba			State, Zip Code) .and 21225
lore,	iges 1 and 3 of Health 11 if item 27 or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	emoval from State		natory or other plac	e)	. 1		City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				ark 7/26/ ss of Facility Go	and the second s		rnie, Maryland rvice, P.A.
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	Physician /Medical Examiner		23d. Part 1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. DiAbete Due to (or as a con	Melli			,		Interval Between Onset and Death
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	To the within To the compl	Me	296. Signature and title of certifier	un		29c. Licens	27415			(Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)				
	Sta	ate.	Itenry Franci 31. Date filed (Month, Day, Year)	S, MD, Registrar's S	ignature	re Wast	inston M	edical	(enter	
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Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar	•	artment of Hea			ne Ng n n c	21107
	Physici	an	1. Decedent's Name (First, Middle,	Last)				Date of Death Month	Day Year	3. Time of Dath
	/Medic		Mary	L	Ja	inney		July 15,		5:30PM M
	Examin	er	4a. Facility Name (If not institution,	•		4b. City, Town, or Loc			4c. County of Death	arasta
			Ft. Washington 5. Social Security Number	MILLERNIUM 6. Sex 7. Age (In yrs.	last hirthday)	Ft. Washi	Under 24 Hrs.	8. Date of Birth	Prince Ge	
	Funeral Director		578-42-1415	1□M 2√F 74	Yrs.		lours Min.	Month, Day, Ye March 6.		place (State or Foreign ntry)
	D		Usual Residence of Decedent					march 0,		
	show	_	10a. State 10b. County Maryland Prince	George's	ty, Town or Lo Accoke					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	be Mi	ecto	10e. Street and Number			1404 71 0-4			0.00	
	with with last	Funeral Director	14716 Livingst	on Road		10f. Zip Code 20607		Tog.	Citizen of What Cou U.S	
	ma 23	era	11. Marital Status	12 Was Doodget Eyes in II	.S. 13. V	Nas Decedent of Hispa f Yes, specify Cuban, N	nic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian,
9	after or ite	Fur	1 Never Married 2 Marrie	Armed Forces? 1 Tyes 2 Ano If Yes, Give	- 1	37	Mexican, Puerto I Specify:	Hican, etc.)	Black, White,	etc. ite
9 9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show ant, the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Opecny.	
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nor	Pages nent of h ant: If ite ary or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State	ee Crer	natory or other place)	Ju1y	18.	inton, Ma	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinational be notified at ance.		21. Signature of Fune 1			. Name and Address of	2005 f Facility		al Home,	
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	/Medical Examiner physician and physician and physician and the prinar-itansil the prinar-itansil physician and ph	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to the following to for as a consect to the following to for as a consect to the following to for as a consect to the following to for as a consect to the following to form to for	juence of): เบษกบอ oij.	TC (AA))(CUACC	SLAN Q	ISALE	Onset and Death
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18	or Attend after death Director: #	fical	3 Suicide 6 Could no	ot be 28e. Place of Injury - At h	ome, farm, str				and Number or Rura	al Route Number,
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			For State Registrar	State o	f Marylan		artmen <i>tificat</i>			ınd M		giene Reg. No	2005	24488
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	/Medic Examin		MARILYN YVONNE 4a. Facility Name (If not institution, give	street and nui	mber)		4b. City,	Town, or	Location o	f Death	JUL		2, 2005 County of Death	
	LXamin	٠.	Saint Joseph	Medica	al Cent	ren			To	WS 01	n		Balt	imore
	Funeral Director		5. Social Security Number 6. Social Security Number 1212-34-7177 Usual Residence of Decedent	ex □ M X 2 X □ F	7. Age (In yrs. 70	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day April 1	/, Year)	9. Birth Col 935 Wash	oplace (State or Foreign Intry) nington, D.C
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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Baltimore, Maryland 21215-0036	e d in b	Be	17. Father's Name (First, Middle, Last) George A. Meidling								(First, Middle, ise Wac		Sumame)	
3	2 should and Men Is marke aumatic	10	19a. Informant's Name/Relationship (19b. Mailir	g Address	(Street a					Town, State, Z	ip Code)
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alF	ilcien: The law certificate has l rector, page 2 !		OS Was and the state of the last									2 X No	death?	217 No
	ystcien: iis certifica director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 X	npatient 2	ER/Outpatier	t 3l DC	A Othe			(Check only o		Other (Spec	ifu)
n of	Attending Physicien: or death. ector: After this certific by the funeral director,	on: T	27. Manner of eath 1 Natural 5 Pending	28a. Date		28b. Time of Injury		8c. Injury Work			8d. Describe h			,,
Division	Attendi death. ctor: A y the fu	icatl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		n of Injug. At h	ama farm ata	M		res 2□1		196 Looption /6	tmat an	d Number or Du	m / Courte Alumbas
Σ	in Pitte	Certification;	4 Homicide determined	build	e of Injury - At he ing, etc. (Specif	y)	eet, ractory	, опісе		-	City or Tow	n, State)	a Number or Hui)	ral Route Number,
	To the Hospitel or within 24 hours after to the Funerel Direct completely filled in I	edical C	(Check only 2 Medical Exam	niner: On the b	e best of my kno	wiedge, deatl	occurred vestigation	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s)	and manner as place, and due	stated. to the cause(s)
	To the Hos within 24 hor To the Fun completely	Med	29b. Signature and title of certifier		nner stated.		290	. License	number			29d. Date	e signed (Month	, Day, Year)
	2		> Zugunda P	mod	ite m.	0	D	414	10		7	My	222	2015.
1	15		30. Name and address of person who	completed cau	se of death (Item	n 23a) (Type,	Print)						<u></u> ·	
		•	JOGINGER F. MEL- 31. Date filed (Month, Day, Year)		D. 7601 Registrar's Signa	1 OSL	ER D	RIVE	TOW	ISON	MARYL	аип.	21204	
	Sta Registi		JUL 2 7 20	11.	eur l		ومعمد							

			1- State of Maryland / Department	artment of F			ene	21100
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) James F. Kordonski. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, a	or Location of Death	2. Date of Death Month July	Day Year 22, 2005	1:50 pm ^M
	Funeral Director	.	7248 Pommel Drive 5. Social Security Number	Sykes If Under 1 Year Months Days	ville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct 21 1	Carro	
	ס	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Md Carroll Sykesville			000 21 1	JII III	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28	al Director	10e. Street and Number 7248 Pommel Drive	10f. Zip Code 21784		100	. Citizen of What Co. USA	untry?
036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or Itams 23a or 28a-f show important: If item 27 is marked other then "naturel", or Itams 23a or 28a-f show appropriately in ury or other traumatic event, the Medical Errar, if at trivial be notified an appropriate.	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No τ,π,τ τ □	Was Decedent of H if Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: whi	, etc.
21215-0036	d within 72 ho giene. er then "natu	Completed	(Specify only highest grade completed) (Give	DO NOT use retired	during most of working	ng .	Sb. Kind of Business/I 1umber	ndustry
Maryland	uld be file Jental Hy rkad othe	To Be (17. Father's Name (First, Middle, Last) James Kordonski		18. Mother's Name Rosie Izd		iden Sumame)	
	and 2 sho ealth and N n 27 is ma						City or Town, State, Z	
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposemetery, crem Lake View	w Memoria	a1 7-26-		c. Location - City or 1	
Bal	permit Depar Import any in		Dance Haract Blow has t	.O. Box 1	^{ess of Facility} Hai 195 Sykesv		ral Home 8 21784	Chapel
	Physician /Medical Examiner	a.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	er the mode of dying No. 100 to 100 t	ng, such as cardiac of		t,	Approximate Interval Between Onset and Death Service Approximate Onset and Death Onset and Dea
8760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	te ren	ial otist	Pase		1 year
.O. Box 6	The law requires that the death certific to the has been signed by the attending page 2 should be detached for use as	Physician/Medical]Ectopic pregnancy] Other <i>(specify)</i>	y		23d. Date of deliv Month	very Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause giv	ven in Part I.		cco use contribute to	
al Reco		Completed		-		24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Division of Vital Records,	S .s .g	ation; To Be	25. Was case referred to medical examiner? 1	26. Place of Death her: 4 \(\text{Nursing Hon} \) y at 2 k? Yes 2 \(\text{No} \)		ce 6 ☐Other (Specinjury occurred	ify)	
Divis	Hospital or Attending I A hours after death. Funerel Director: After etaly filled in by the funer	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, strategies building, etc. (Specily)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated. 29b. Signature and title of certifier	occurred at the tin vestigation, in my o	opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	Z Z Z S		· 1/samon	HY	16326		Plate signed (Month	OS S
1	0		30. Namerand address of person who completed cause of death (Item 23a) (Type, 6 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 GEOVE	getown Bl	N, 51d	esby, Mo	121784
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 7 2005	W .				

		•	For State Registrar	State of	Maryland / D	epar <i>Certi</i>	tment of He ficate of D	ealth ai Death	nd Me		iene _{eg. No.}	05	244	90
	Discourse to the		1. Decedent's Name (First, Middle	, Last)					:	2. Date of Deat Month	th Day	Year	3. Time o	f Death
	Physicia /Medic		SYED VIRASAT	SHIKOH	KASHMIRI				J	ULY	19 ′	2005	10:30	АМ
	Examin		4a. Facility Name (If not institution,	give street and numb	oer)	4	b. City, Town, or	Location of	Death			inty of Death		
			SHADY GROVE ADVENT				ROCKVILLE	W III-da-O	4 Uzo			rGOMERY		
	Funeral		5. Social Security Number 243-76-1510	6. Sex 7.	Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day	, Year)	9. Birth	place (State	or Foreign
	Director	-	Usual Residence of Decedent		68	113.				JULY 5, 1	1937	INDIA		
	land DW	-	10a. State 10b. County		10c. City, Town	or Loca	tion						10d. Inside C	ity Limits
	Mary f sh	ō	MARYLAND MONTCOM	EDV	GAITHERS	BLIDC							1 Tyes	2 🗌 No
	288 7	Director	MARYLAND MONTGOM 10e. Street and Number	EKI	UATTIERS	bolla	10f. Zip Code			1	0g. Citizen	of What Cou	ntry?	
	hours after deeth with the Maryland turel', or Items 23e or 28e-f show al Exeminer must be notified at		11541 BRANDY HALL	IANF			20878				U.S.A.			
	ms 2	Funerai	11. Marital Status	12. Was Deced Armed Force	ent Ever in U.S.	13. Wa	s Decedent of His es, specify Cubar		in? (Spec	ify Yes or No-		Race - Ameri		
0	ours after o	Ī	1 ☐ Never Married 2 ☐ Marri	ed 1 Yes 2	No	1	v	Specify:	rueito n	ican, etc.)		Black, White, ec <i>ify:</i>	OIC.	
2-0030	urel',	d by	3 Widowed 4 Divorced	Year or Dat	es:		2 103 2 2 110	opcony.				IN	DIAN	
ភ	72 hours "naturel", olical Exe	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a.	(Giva kit	nt's Usual Occupa nd of work done d O NOT use retired)	urina most o	of working	9	16b. Kind	of Business/In	dustry	
Z	within 72 ene. than "nal	ш	Elementary/Secondary (0-12)	College (1-4							N 1 11			
7	Hygie Hygie other ant, II		17. Father's Name (First, Middle, I		RES	EARCH	IER	18. Mother	's Name	(First, Middle,	N.I.H.			
Maryland	be de la participa de la parti	Be c	SYED MOHAMMAD					SHAN	DAR	BEGUM		ŕ		
<u></u>	s 1 and 2 should I Health and Men Item 27 is marke other treumatic	우	19a. Informant's Name/Relationsh	nip (Type, Print)	19b.	Mailing	Address (Street a	nd Number	or Rural	Route Number	r. City or To	wn, State, Zij	Code)	
	and 2:		SYED KAZMI-SON		115	41 RR	RANDY HALL	LANE	GALTH	FRSBURG.	MARYLA	ND 2087	8	
ค์	Hea Hem Item othe		20a. Method of Disposition		20b. Place of	Disposit			Da			on - City or T		
9	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		MD NATIO				/20/2	005	LAURFI	MARYLA	ND	
Baltimore,	C 49 7		21. Signature of Funeral Service I		•	22. N	Name and Address	s of Facility				7771111 271	110	
ñ	Depart Import any Inj		1 (Imanda	Kude	UKA	760	CK FUNERAL 11 SANDY SF	. HOME, PRING R	INC.	LAUREL, I	MARYLAN	ID 20707		
r			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	used the death. Do n	not enter	the mode of dying	, such as c	ardiac or	respiratory arr	est,		Approxima Interval Be	ite itween
	Physician		Immediate Cause (Final		FSPIRA								Onset and	Death
	/Medical		disease or condition resulting in death)	a. Due to (o	r as a consequence	of):	9 ///	WK					NOW I	
	Examiner		Cognostially list conditions	h	VEIM	NI	1						DAY	
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Ď,	be executed sician and burial-transit	<u> </u>	resulting in deathly case	Due to (o	r as a consequence of	or):								
8/60	cate b	dical		d										
٥ ×	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	IF FEMALE:	23c If yes outco	ome of pregnancy						224	Data of dalis	201	
ZOZ	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bin	th 2 Fetal death		ctopic pregnancy Other (specify)				230	Date of deliv Month	-	Year
j		yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		300	outer (specify)							
<u>.</u>	The law requires thet the de sie has been signed by the a bage 2 should be detached f	, Ph	Part II. Dther significant condition	ns contributing to dea	th but not resulting in	the und	lerlying cause give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of	death?
ds	uires sign ld be	d by								1 🗆 Y	es 2□N	o 3□Pro	bably 4	Onknown
Ö	w require been sign	Completed								24a. Was a	an 2	4b. Were auto	opsy findings	available
Ď	he lav e has	mc					····			autops	med?	4b. Were auto prior to co death?		cause of
Vital Records,		e Co	25. Was case referred to medical				<u>-</u>	OS Diago	of Dooth	1 ☐ Yes (Check only or	2 No	1 □ Yes	2 No	
	Physician: The la r this certificete has ral director, page 2	To B	examiner? 1 Yes 2 No	Hospital:	patient 2 PER/Ou	tnatient	3□ DOA Othe	· ·		e 5 ☐ Resid		Other (Speci	fv)	
Division of	g Phy er this eral c	n: T	27. Manne of Death	28a. Date of	Injury 28b. T	Time of	28c. Injury Work			8d. Describe h			.,,	
0	nding ath. r: Afte	atio	1 Accident 5 Pendin investig	9	Day Year) II	njury		.f ∕es 2 □ N	lo					
N N	l or Attending Ph after death. Director: After th in by the funeral	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 289. Place C	f Injury - At home, fa	rm, stree	et, factory, office		2	8f. Location (S City or Tow		umber or Rur	al Route Nu	m <i>ber</i> ,
5	tel or rs afte el Dli	Certification:			g, oto. (opcony)									
	Hospitel 24 hours Funerel (ely filled		29a. Certifier 1 Certifyin 2 Medical	g Physician: To the b Examiner on the bas	est of my knowledge	death o	occurred at the tim	e, date and	place, a	nd due to the o	ause(s) and	manner as	stated.	(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Medical	one)	and manne	r stated.									/
	To vith	2	29b. Signature and title of certified	//			29c. License		-			gned (Month,	-	
	ex.		· A	N	• // .		060	541	39		THL,	19	, 20	05
	21		30. Name and address of person	7	of death (Item 23a)	(Type, Pi	DOO.	-		e				
C		rio.	31. Date filed (Month, Day, Year)	LE, M. 32. R	istrar's Signature	ONY	Grove	1	wr	NINI	100	V PILL	oc.	
	Sta Regist		JUL 2	7 2005	gistrar's Signature	1	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles L. Kleff, Jr. Ju₁y 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 21, 1934 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★M 2 F 70 217 30 3887 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Maryland Director Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1504 Puffin Court U.S. 21122 death v Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Iem 27 ie marked other then "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4 or 5+) Truck Driver Valley Protein Co. 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Kleff, Sr. Evelyn Disney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Kleff / wife 1504 Puffin Court Pasadena, Maryland 21122 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of History
Important: If iter
any injury or oth 1 ¬Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Mem. Pk. 7/29/2005 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 nominicish 23a. Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List grily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) tail /Medical **Examiner** Umperten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit SWOK resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page certificate 1 ☐ Yes 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No ည 3□ DOA 2 DER/Outpatient 6 DOther (Specify) Hospice 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) - YTa

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

		1 - State Amend Item I Registrar 1. Decedent's Name (First, Middle, Las.		Department of Health and Certificate of Death	2. Date of Deat	th	2 1 1 9 3. Time of Deat
Physici /Medic Examir	al	Nataa Ayana 4a. Facility Name (If not institution, give		4b. City, Town, or Location of De	July 24	Day Year 2005	16:35
Funeral Director		Prince George Ho 5. Social Security Number 6. Se 215 96 3184 Usual Residence of Decedent	X 7. Age (In yrs. last bit	Cheverly rthday) ft Under 1 Year ft Under 24 H Months Days Hours M	n. (Month, Day,	Prince (Year) 9. Birt Co 1, 1976 Was	hplace (State or For
or 28a-f ahow e riolified at	Director	10a. State 10b. County Maryland Prince 10e. Street and Number	George's Clin		1	0g. Citizen of What Co	10d. Inside City Lin 1 ☐ Yes 2√
Department of Health and Mental Hygiene. Important: If item 23a or 28a-1 ahow Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination of the rectified all sones.	by Funerai [8315 Schultz 11. Marital Status XXX Never Married 2 Married 3 Widowed 4 Divorced	Z Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	20735 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	United S 14. Race - Ame Black, White Specify: Black	ncan Indian, e, etc.
ygiene. her than "nature t, the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	cation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) erical	vorking	Inc 16b. Kind of Business/ Government	•
Mental Hy arked oth atic even	To Be	John C. Kennedy			ame (First, Middle, Mada F. LaF		
nealin and tem 27 is my ther traumy		19a. Informant's Name/Relationship (T) Brenda F. LaFayet 20a. Method of Disposition	te (Mother)	Mailing Address (Street and Number or Straverse Way, 1315 Schultz Road C	ort Washi Linton, MD	City or Town, State, Z	20744
Department of Important: If it is any injury or conce.		1 □ No Yirial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Server Lights	Removal from State Lincol	ny, crematory or other place) n Cemetery Aug 1, 2 22. Name and Address of Facility Le	.005	Suitland,	Maryland
2 5 9 9		23a. Part1. Enter the disease, or compl	ications that caused the death. Do	Alexandira Ferry	Rd, Clint	on, MD 2073	Approximate
sician ledical aminer		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	aSepsis				Interval Betwee Onset and Dea
physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire, underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due t	sease			
or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▼ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delin	very Day Year
been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to s XXNo 3□Pro	the cause of death
ificate has been or, page 2 should	e Completed	25. Was case referred to medical				prior to content? death? No 1 ☐ Yes	opsy findings avail ompletion of cause 2 \(\text{No} \)
	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Other	Home 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
ral Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fail building, etc. (Specify)		City or Town,	_	
To the Fune	edical	29a. Certifier 1 Check only one) 1 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and plac d/or investigation, in my opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner as a te and place, and due t	stated. to the cause(s)
To the comple		29b. Signature and title of certifier	Aug	29c. License number		d. Date signed (Month. $7/2.5/C$	Day, Year)
		30. Se and address of person who co		Central Ave, Landon	ND 00	705	

		4		Department of Health and M	2005 01100
			- negistral	Certificate of Death	Reg. No. 2005 244 93
	Physicia		1. Decedent's Name (First, Middle, Last)		Month Day Year
	/Medic	al .	Betty Jane Kelly		July 26, 2005 9:10 A M
****	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
			6517 Blackhead Road	Middle River	Baltimore 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Yrs. Months Days Hours Min.	(Month, Day, Year) Country)
	Director	-	212-46-3103 59 Usual Residence of Decedent		March 7, 1946 Maryland
	and w	1	10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
	/anyl	5	Maryland Baltimore Middle	Divor	1 ☐ Yes 2 💆 No
	the h	Directo	Maryland Baltimore Middle 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	with	₫		21220	U. S. A.
	ns 23	Funeral	6517 Blackhead Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No- 14. Race - American Indian,
	fter d	ᆵ	1 Never Married 2X Married 1 □ Yes 2X No	If Yes, specify Cuban, Mexican, Puerto	
3	al', or	b	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No Specify:	Specify: White
ŏ	within 72 hours after death with the Maryland ene. ene. Than "naturel", or items 23e or 28e-f show fre Noviral Examiner must be notified at	ted		Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
212	7 cic	Pie Pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
2	d with	Completed		memaker	Own Home
פ	be filed within 72 hours after death with the Marylan at Hygiene. It all Hygiene. It is Marylan insturel; or Items 23e or 28e-f show and ther than "naturel; or Items 23e or 28e-f show and the Marylan in the Marylan	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Sumame)
Maryland 21215-0036	2 should be fitled withir and Mental Hygiene. Is marked other than eumatic event, Ire M	2	Leroy D. Burrs, Sr.	Nellie	Irene Langley
a	and la				ral Route Number, City or Town, State, Zip Code)
Σ	and alth		Taur nerry (reserve		Middle River, Maryland 21220
ore	of He		20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State 20b. Place or cemete.		Date 20c. Location - City or Town, State
Ĕ	Pag nent ant: I		`4 □ Donation 5 □ Other (Specify) Holly	ry, crematory or other place) 7/2 Hill Mem. Gard. 200	Middle River, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is markad eny injury or other treumatic es once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bruzdzinski Funera	al Home PA
_	20529	1 11	John W. Dwikowske	1407 Old Eastern A	
			23a. Pan1. Enter the disease, or complications that caused the deeth. Do block, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
	Pnysician	i 23	Immediate Cause (Final disease or condition	400m1a	
	/Medical		resulting in death) Due to (or as a consequence	911 1 011	110,001
П	Examiner	.	Sequentially list conditions, b.	1000 DM	TWEEK
	pig sit	ine	Sequentially list conditions, if any, leading to immediate cause. Entar Unantifying	oi):	
7	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	of):	
8760,	cate be executed physician and the burial-transit	E E			
	icate l physi s the t	dical	d		
9 x	ding	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	ath c	ian	23b. Was decedent pregnant 1 Live birth 2 Fetal death in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)	Month Day Year
o <u>i</u>	the de	ysic	1 ☐ Yes 2 🖫 No 9 ☐ Unknown		
<u>α</u>	that t ed by detai	P.	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds,	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as		CVA		1 Yes 2 No 3 Probably 4 Unknown
Ö	request	Completed	Dullman D. Mileson To	all one	24a. Was an 24b. Were autopsy findings available
ž	has has	E E	- The said the said to be	1 000 111	autopsy prior to completion of cause of death?
a			PV D	26 Place of Dea	1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
Ξ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No Hospital: 1 □ Inpatient 2 □ EP/O	Other	lome 5X Residence 6 □Other (Specify)
of	T = G	J.	27 Manner of Death 28a, Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how injury occurred
O	ding Phy Ih. After thi funeral	tion	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	or Attending after death. Diractor: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, f.	arm, street, factory, office	281. Location (Street and Number or Rural Route Number, City or Town, State)
S	- 0	Certification;	4 Homicide building, etc. (Specify)		Oily of Yours, States
	To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely filled in by the	sai C	29a. Certifier (Check only (C	e, death occurred at the time, date and place	o, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)
	the H in 24 the Fi	ledical	one) and manner stated.		
	To 1 To 1	Σ	29b. Signature and title of celtrifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		MILLO MAN M	0 100000	J + /27/05
	'n		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	Almon MA 21220
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	account to I	MALLONG TID & 15
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	South a	
	Regist	421			

			1 - For State Registrar	State of Maryland /	Depa		Health and	Mental Hy	giene (9 0 5	24494
	Physici		Decedent's Name (First, Middle, Last CHARLES EDWARD L.			undate of		2. Date of Dea	ath	2005	3. Time of Death 4:13 P M
	/Medi Examir		4a. Facility Name (If not institution, give FREDERICK MEMORIA	street and number)		4b. City, Town, FREDERI(or Location of Deat		4c. Cou	inty of Death DERICK	
	Funeral Director		217 12 1017	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt May 14	, 1921	9. Birth	place (State or Foreign ntry Land
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	.k Jeff							10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a	ai Direc	10e. Street and Number 3714 Jefferson P	ike		10f. Zip Code 217	55		10g. Citizen	of What Cou	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanture must be rectified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1& Yes 2 □ No If Yes, Give Year or Dates:1941-1945		Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecify: W	
21215-0036	vithin 72 hc ne. han "natur n Medicul	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	(Give life. L		during most of wor d)	king		f Business/In	
Maryland 2	2 should be filed withli and Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Joshua W. La	apole	Ma:	intenance	18. Mother's Nan	ne (First, Middle, Fawley			ducation
	and 2 shorell and N 27 is ma		19a. Informant's Name/Relationship (Ty Mrs. A. Pauline La		9b. Mailin 3714	g Address (Street Jefferso	and Number or Ru on Pike,	ral Route Numbe Jefferso	r, City or To	wn, State, Zip 21755	Code)
Baltimore,	Page ent o nt: if		20a. Method of Disposition 42 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	cemet	erv cren	sition (Name of natory or other pla Cemeter	_{сө)} y July 22	Date 2., 2005		on - City or To	own, State Maryland
Balt	permit. Departm importal any inju		21. Signature of Funeral Service License	MO0255	10	Keeney 2 6 East (and Basfo Church St	rd PA Fu ., Frede	neral rick,	Home MD 21	701
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	ne cause on each line.	arti	1.		or respiratory an	est,		Approximate Interval Between Onset and Death
. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a consequence d. 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death		Ectopic pregnancy Other (specify)	,		1	Date of delive	ery Day Year
, P.O.	s that the de ned by the a e detached	by Phys	9 Unknown Part II. Other significant conditions con	9□ Unknown atributing to death but not resulting			en in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
cords	w requires to been signer should be a							1 ☐ Ye	9s 2 No		ably 4 Unknown
Vital Records,	The ate h page	e Completed	25. Was case referred to medical				00 Plant of D	autops perform 1 Yes	ned? 22 No	prior to cor death?	psy findings available inpletion of cause of
of	Phys this al dii	ation: To B	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 EP/O 28a. Date of Injury (Month, Day Year) 28b.	Outpatient Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing Ho	th (Check only on ome 5 - Reside 28d. Describe ho	ence 6 🗆 C		9
Division	i giệc c	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		28f. Location (St City or Town	i, State)		
	To the Hospital within 24 hours a To the Funeral t completely filled	Medicai	one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	e, death nd/or inv	estigation, in my o	pinion, death occur	and due to the cared at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
)	Z M	2/	29b. Signature and title of certifier			29c. Licens	87/78		9d. Date sign	oned (Month, L	Day, Year)
	(U)		30. Name and address of person who co	Fleming, M.D.,			venue, Bi				21716
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JUL 2 7 20	32. Pigistrar's Signature	6	arte					

			1 - For State Registrer	State o	of Marylar	-	artment of F		ind M		giene Reg. NØ () (15	21.1.05
	Physicia	an	Decedent's Name (First, Middle							2. Date of Dea Month	Day	Year	S. Time of Death
	/Medic	al	ALEXANDER 4a. Facility Name (If not institution)	LEWIS	umber)		4b. City, Town, o	e Logation of	f Dooth	July	Zi Z	0 05	8-03 UW
	Examin	er	SAMT AG	15 ()	FIRITE	+ CARD	Bal	tim	ORI	1=	N/A		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birtl (Month, Da)	h		place (State or Foreign
	Director		215-50-7155	X M 2□ F	5	8 Yrs.	Months Days	Hours	MICI.		1946		YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits
	the Marylar 28e-f show	to	MARYLAND N/A			ם אד.	TIMORE						1⊠Yes 2□No
	ith the	Director	10e. Street and Number			DAL	10f. Zip Code				10g. Citizen of V	Vhat Cour	ntry?
	death with the Maryland ms 23a or 28e-f show r must be notified at		2549 FRANCIS	STREET			212	217			U.S	.A.	
	tems	Funeral	11. Marital Status	Armed F	edent Ever in U	J.S. 13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Americ	ean Indian, etc.
36	filed within 72 hours atler death w Hygiene. ther then "naturel", or items 23a ant, Ite Modical Examinar must	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🛣 Divorced	ed 1 XYes If Yes, G	2□No ive Dates: 66/6		1 ☐ Yes 🎎 🗓 No	Specify:				BLAG	
Ş	2 hour		15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation			16b. Kind of Bu		
215	hin 72 a. an "na	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College ((Give	kind of work done of DO NOT use retired	during most d)	of worki	ng			,
213	ad wit	Completed	12th grade			CAB	DRIVER				TRANS	PORTA	ATION
pur	be fill ntal Hy od oth	Be	17. Father's Name (First, Middle, I	.ast)							Maiden Sumam	e)	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than "treumatic event, the Max	٦	EDDIE LEWIS 19a. Informant's Name/Relationsh	in (Tuna Print)		10b Maili	ng Address (Street			LEE LU		Ctata Zi-	Code
Ma	s 1 and 2 should be filed within 72 hours after death with the Maryla f Healith and Mental Hygiene. If Healith and Mental Hygiene. If the file of the transition of the file o		Annie M. Lewis				Francis					555	
ē,	s 1 ar		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place			ate CINC	20c. Location -		
e E	Page nent o int: If		1 🖾 Burial 2 □ Cremation 1 □ Other (Sp		State	-	FOREST		7-29	-05	OWINGS	MILLS	S, MARYLAND
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once.		21. Signatur of Funeral Service I	icensee	,	22	2. Name and Addres	ss of Facility	COM	MIINTTV	FIMEDAT	номт	F D A
	90 E 2 9		Darlace	18		1	206 W NOR	VA HTS	ENUE			пом	
			23a and Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deal each line.		1190	10-21			1176		Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)		enary	Arte	nurler.	stic	Vas	cular 1	Disense	V.	nknown
Circuit Circuit	Examiner			Due to	(or as a consec	quence of):							
	sys.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a nonsec	lianoa (if):						- 7/1	
	cuted nd Iransit	Examiner	that initiated events	c									
50,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to	(or as a consec	quence of):							
38760,	cate t physic the b	Physician/Medical		d									
»×6	seath certifica attending phater use as t	√Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn						23d Dat	e of delive	in.
X ä	death	iciar	in the past 12 months?	4□Preg	birth 2 Feta nant at time of c		Ectopic pregnancy Other (specify)	'			Moi		Day Year
50	that the deatl ed by the atte detached for	hys	9 Unknown	9□ Unkr	iown								
S, I	be ign	by	Part II. Other significant condition			sulting in the u	nderlying cause give	en in Part I.					e cause of death?
or br	v requii been s should	Completed	<i>J</i>	Diabeto	25					1 L Y	es 2□No	3 Prob	ably 4 Winknown
360	≥ T 0	mple								24a. Was a autops perfor	sy c	Vere autor prior to con leath?	psy findings available inpletion of cause of
	i cie n: The lav certificate has rector, page 2	e Co	QE Was one referred to madical							1 Yes	2/10 1	Yes	2 No
` <u>≒</u>	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes Pho	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA Oth			(Check only or	<i>ne)</i> ence 6 □Othe	ar (Specific	4
	g Phys er this eral dir	\vdash	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o					ow injury occurr		/
\mathcal{U}_{Sion}	uttending death. ctor: Aft / the fun	atlo	1 SNatural 5 ☐ Pending investig	ation	nii, Day 19ai/	Injury		Yes 2□N	lo				
Z iš	i or Attending Physicien: The lar after death. Director: After this certificate has I in by the funeral director, page 2	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place	e of Injury - At h	ome, farm, str fy)	eet, factory, office		2	28f. Location (S City or Tow		er or Rura	l Route Number,
70	Hospitel or Attending 24 hours after death. Funerel Director: Afte tely filled in by the fune	Ce	Constitute to Constitute	- Dhusisian T. III									
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledical	29a. Certifier Certifyin (Check only one) Medical I	xeminer: On the b	e best of my kno pasis of examina nner stated.	owledge, deat ation and/or in	n occurred at the time vestigation, in my of	ne, date and pinion, death	l place, a n occurre	and due to the c ad at the time, d	ause(s) and ma late and place, a	nner as stand due to	ated. the cause(s)
_	To the To the Comple	Me	29b. Signature and title of certifier				29c. License	e number		2	29d. Date signed	(Month, I	Day, Year)
			> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	mann	MAND		nos	5584	9		Tille Zu	ממקרו	5
_/	10		30. Name and address of person	vho completed cau	se of death (iter	п 23а) (Туре,	Print)	<u>) ب ر -</u>	4		- 1.		, /
	l		Doutt Berges	on It	Agnes	My Jugar	900 Print) 900	Caton	Ac	ne is	6/timor	e N	rangerd
	Sta Registr		31. Date filed (Month, Day, Year)	2005	negistrar's Signa	A A	30/21						
			WOL N.	- Comment	Marine &	17							

		1	For State Registrar	State of M	aryland		rtment of F		•	giene Reg. No.2 (205	01100
	Physicia	ın	1. Decedent's Name (First, Middle, La	est)		MC	Lee		2. Date of De Month	-	Year	S. Time or Death O
	/Medic Examin		Ta. Facility Name (If not institution, give	re street and number)	10	oter	4b. City, Town, o	r Location of Dea	th	4c. Cou	nty of Death	20 (0
	Funeral Director		5. Social Security Number 6. S		e (in yrs. ia	ast birthday) Yrs.	If Order 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	h y, Year) , 1914		ace (State or Foreign ry) n Carolina
	aryland ehow		Usual Residence of Decedent 10a. State 10b. County MD Oueen A	nnes		Town or Lo					10	0d. Inside City Limits 1 ☐ Yes ※XXNo
	with the M or 28e-f	Directo	10e. Street and Number 411 Bolton Woods		Dual		10f. Zip Code 2166	Ω		10g. Citizen u	of What Coun	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. It has teem 27 is marked other then "naturel", or Items 23e or 28e-f ehow other treumetic event, Ite Madral Examination until the notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give	1	ı		lispanic Origin? (Specify Yes or No rto Rican, etc.)	- 14. F	Race - America Black, White, e scify: Whi	etc.
21	within 72 hours iene. then "naturel" its Mcdical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give life. I	lent's Usual Occup kind of work done OO NOT use retired	during most of we	orking		f Business/Ind	ustry
CA	ould be filed with Mental Hygiene arked other ther etic event, Itte	Be Cor	3 17. Father's Name (First, Middle, Las	r)		Hon	emaker	18. Mother's Na	ame (First, Middle		Home	
Maryland	2 should b and Ment is marked sumetic e	To	Lum Ladford 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street	Bertha and Number or F	Sparks Rural Route Numb	er, City or Tox	wn, State, Zip	Code)
	1 and 2: Health ai em 27 is other treu		Louise Charlton	- daughter	1			ods Road	l, Sudler			21668
nore	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci		CE	emetery, crer	sition (Name of natory or other place Ige Mem.		^{Date} 27/2005		on - City or To .dge, M	
Baltimore,	permit. Pages 1 a Department of Hec Importent: If item eny injury or othe		21. Signature of Fune Pervice Lice	nsee		Ga 72	50 Washi	ufman Fu naton Bl	vd. Flk	ridge.	ieadpwr MD 2	odge MP, Inc.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause one cause on each I	d the death	Do not ent	er the mode of dyin	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Inysician /Medical Examiner	ner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a Due to (or as	One	her	Kve	- He	art F	anu	re	
8760,	sath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):						
.O. Box 68	he death certifica the attending ph thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			Date of delive Month	ry Day Year
<u>a</u>	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the u	nderlying cause gr	ven in Part I.		obacco use c Yes 2 🗆 No		e cause of death?
Vital Records,	2 8	Completed								2 No	death?	osy findings available npletion of cause of 2 \(\text{No} \)
	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💆 No	Hospital: 1 Inpati	ent 2,1⊠	ER/Outpatier	t 3 DOA Ot	ner.	eath (Check only) Home 5 Resi		Other (Specify	')
Division of	Jing After fune	Certification: T	27. Magner of Death 1. Natural 5 Pending 2 Accident investigation	ho l		28b. Time o Injury	M 1□	ry at rk?] Yes 2 □ No	28d. Describe			
Divis	el or Att s after de sl Directo	Sertific	3 Suicide 6 Could not determined	a 289. Place of in	jury - At ho tc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	umber or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical (hysician: To the best miner: On the basis of and manners	of examinat							
	To the vithin comp	M	29b. Signature and title of certifier	HA N	20		29c. Licens	se number 061321			gned (Month,	
	0	٤	30. Name and address of person who				Print)		MD 21620			-
	: Sta Regist		31. Date filed (Month, Day, Year)	32. Regist				LI COWITY	21020			

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this After

1- State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Ruth Elizabeth Mosmiller July 21, 2005 9:30am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 343 S. Calhoun St. Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Dec. 9, 193 213-26-3812 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** 1 ☐ M 2 🛣 F Director 1930 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits TX Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 S. Calhoun St. 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 le marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franklin Virginia Steffey Lee Richard James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s if Health an 1509 Clearfield Circle, Severn, MD 21144 Francis J. Mosmiller Jr., (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If Ite 1 Burial 2 □ Cremation 3 □ Removal from State Department of important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7/25/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mun card **Physician** disease or condition resulting in death) min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Naturel 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending Injury 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier DO047540 aman ov Caroline Street, Baltimure, MD address of person who completed cause of death (Item 23a) (Type, Print) Kedenda M 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Physic	ian	1. Decedent's Name (First, Middle, Last)	Delores		41105	UII.			2, Date of De Month	Day	Year	3. Time of Deat	
/Medical Examinér		4a. Facility Name (If not institution, give street and number) 5608 Park Heights Avenue 4b. City, Town, or Location of De						of Death					
Funeral Director		5. Social Security Number 212-40-4218 Usual Residence of Decedent	м 2 X F	64 Yrs	Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 11 28	th y, Year) 40	9. Birth	place (State or For Intry) VA	
t show	ror	10a. State 10b. County 10c. City, Town or Location 10d. Inside									10d. Inside City Lin		
or 28e	irec	10e. Street and Number 10f. Zip Co					Code 10g. Citizen of What Country?					intry?	
23a d	rai	409 Seagull Ave		21225					U.S.A.				
al, or items Examiner n	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						14. Race - American Indian, Black, White, etc. Specify: Black		
ane. than "natural", or items 23a or 28e-f show na Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5-	(G	icedent's Usu ive kind of wo e. DO NOT u	rk done d	turina mos	t of worki	ing	16b. Kind of	Business/Ir	ndustry	
f Health and Mental Hyglene. Item 27 is marked other than "netural; or items 23s or 28s-4 show other traumatic event, the Medical Examinar must be notified at	Cou	10th grade	na		1fi11m	ent (Harte		S	
	Be	17. Father's Name (First, Middle, Last)					18. Mothe	ar's Name	(First, Middle,	Maiden Sum	ame)		
	၉	Charlie Anderson 19a. Informant's Name/Relationship (Type	o Grint)	105 14	77 4-4-4	(2)			Herring				
th and Men 7 is marke traumatic			,	1000					il Route Numbe			p Code)	
Department of Health important: if Item 27 any injury or other tra once.		Richard Moore—Husba 20a. Method of Disposition 1 (XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of Di cemetery,	sposition (Nar crematory or o	me of other place	9)	С	more, Note	20c. Location	1 · City or T		
Department of h important: if fte any injury or of once.		21. Signatur F neral Service License	MIN	Garriso	22. Name ar		s of Facilit	y Ma	rch F/H Avenue				
iysician Medical kaminer		233. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Islaes or injury that imitated events Due to (or as a consequence of): Due to (or as a consequence of):											
daath certificate be executed e attanding physician and nd for use as the buriat-transit	an/Medicai Examiner	Due to (or as a consequence of): d											
by the att	Physician/M	in the past 12 moorhs? 1 Yes 2 Ao 9 Unknown 9 Unknown 1 Other (specify)								Month Day Year			
been signed l should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par					n in Part I.		23e. Did tobacco use co ute to the cause of death? 1 Yes 2 0 3 Probably 4 Unknow				
ding Physicien: The lav. h. After this certificate has funeral director, page 2	Completed								24a. Was a autop perfor	sy	prior to co death?	opsy findings availa impletion of cause of	
	ation: To Be	examiner? 1 Yes 2 No								SISTER" HOUSE			
000	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
within 24 hours aft To the Funeral Di complately filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
withi.	M	29b. Signature and title of certifier RAM J. Kandwein M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAM S. KARIPINE NI 202 W. MAPLERD, LINTHIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 7 2005								29d. Date signed (Month, Day, Year)			
		30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Typ	e, Print)	RIF	RD	2 10	THIC	UM	H(1)	11090-	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 2005 **Physician** Coretha E. H. Miller 2Ō 10:45 p M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1807 Gwynns Falls Parkway Balto Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. 1 M 2X F Months Hours Director 101 11-22-1903 220-22-2224 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "naturel", or items 23a or 28e-1 show the Medical Examiner must be notified at 1√2 Yes 2 □ No Balto N/ADirector Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 1807 Gwynns Falls Parkway USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Specify: Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Domestic Worker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Homes N/A8th grade is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file tment of Health and Mental He tent; If item 27 is marked off jury or other treumatic even Be Alice Harcum 2 Hollin Harcum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Gwynns Falls Parkway Balto, Md 21217 19a. Informant's Name/Relationship (Type, Print) 1807 Gwynns Falls Parkway Lorraine C. Miller - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department c Importent: If any injury or once. Arbutus Memorial Pk 7-26-2005 Arbutus, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Balto, Md 21215 Wabash Avenue 4300 Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or se a consequence of): **Examiner** Sequentially list conditions, I dry Lading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician Completed by Physiclan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day be detached for in the past 12 mopths? 4□Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ischursis should 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2 No page 2 s 1 ☐ Yes 🎾 No certificate 1 ☐ Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 🗌 Homicide To the Hospitel within 24 hours a To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier arsh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Backer narsna 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. 2.005 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev Voo **Physician** BERNICE MITCHELL 3:30 AM TULY 23 2005 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 10 29 26 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Hours 1□M **2**0 F Months Days Vrs 78 Director 215-16-3643 ΜD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYYes 2 □ No Director NA Baltimore 10e Street end Number 10g. Citizen of What Country? 10f. Zip Code Funeral 5515 Adleigh Ave U.S.A. 21206 14. Race - American Indian, Black, White, etc. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status 1 ☐ Yes 2 X No tf Yes, Give Yeer or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Department of Elementery/Secondery (0-12) Cotlege (1-4or 5+) 12th grade Asst. Supervisor 2yrs Social Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Golden Carviskeene Eva Bell Guice 19a. Informent's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Phyllis Mitchell-Ramirez
20a. Method of Disposition 5515 Adleigh Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place)
Malones United 20c. Location - City or Town, State 1 M Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/30/05 Madison, Md Methodist Church 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
March F/H West 4300 Wabash ave, Baltimore, Md 21215 23a. Part 1. Enter tife disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer talure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical UTERINE CANCER Examiner Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed ettending physician end for use es the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FAILURE ģ A NEMIA 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? page 2 hes 1 ☐ Yes 2 BNo 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No After this s efter death.

I Director: After this of in by the funerel d 27 Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 10061789 19m -1 JULY · NYD 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

LOFFAINE 31. Dete filed (Month, Dey, Year)

ORIGINAL

32. Register's Signeture

Bloomer

OFORIAWUAH, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239